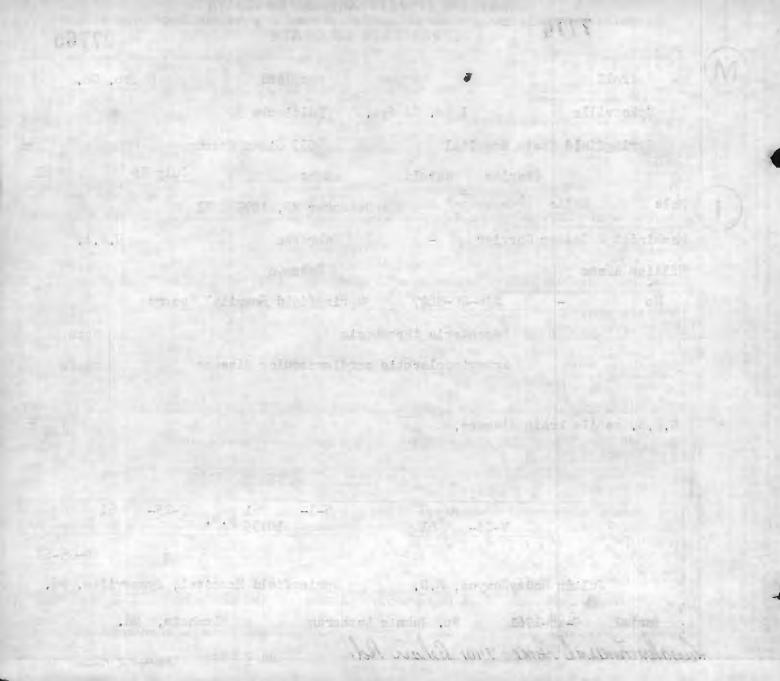
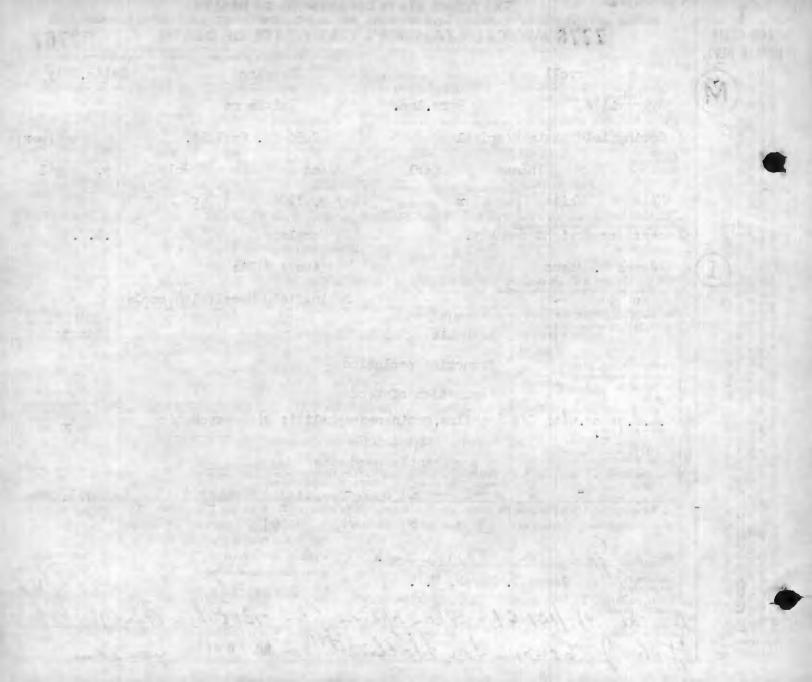
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATESPICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decreesed lived, If institution: Residence before admission) a. COUNTY Carroll MARYLAND Balto. Co. Maryland b. CITY OR TOWN (if outside corporete limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN III outside corporate fimils, write RURAL and give nearest town write RURAL and give nearest town) 1 mo. 24 dys Svkesville Baltimore 34 e. IS RESIDENCE ed. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS ON A FARM? papers. Pag in 72 hours YES NO 9033 Simms Avenue State Hospital 3. NAME OF 4. DATE Month DECEASED OF DEATH 19 61 (Type or print) July Charles Harold Adams and conn 9. AGE (In years | IF UNDER I YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 5. SEX last birthday) Months | Days Hours White Male WIDOWED DIVORCED December 23, physician e remove 10a. USUAL OCCUPATION (Give kind of work 12. CITIZEN OF WHAT COUNTRY 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) dona during most of working life, even if retired) U.S.A. Machinist & Letter Carrier Nebraska 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME William Adams Unknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) | (Ifyesgivewarordatesofservice) Springfield Hospital Records No 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Mesenteric thrombosis days IMMEDIATE CAUSE (e) DUE TO Arteriosclerotic cardiovascular disease vears geve rise to immediate ceuse DUE TO (a), sleting the underlying PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTOPSY PERFORMED? C.B.S. senile brain disease. NO & 2Db. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert I or Pert II of item 18.) 2De. ACCIDENT WAS UNDERLYING IT OR CONTRIBUTING CAUSE OF DEATH 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) (Stata) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) While Not While Hour a.m. at work et work DIRECTOR phoods 22b. DATE SIGNED ATTENDING DIRECTOR PHYS. PHYS. death, Page 4 r 22d. ADDRESS 22c. PHYSICIAN'S Julian Radzykewycz, M.D. Springfield Hospital, Sykesville, Md. 23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) St. John's Lutheran Blenheim. Buria ADDRESS 25a, REC'D BY REGISTRAR 25b, REGISTRAR'S SIGNATURE VR A15 (4) 15M 9/60



RYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before ada. COUNTY IL COUNTY within 24 hours Carroll MARYLAND Marvland b, CITY OR TOWN (if outside corporate limits. c. CITY OR TOWN (If outside corporete limits, write RURAL and give nearest town) E. LENGTH OF STAY IN 16 write RURAL and give neerest town) Baltimore Swkesville months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS a. IS RESIDENCE ON A FARM? YES NO Y State Hospital Rossiter 3. NAME OF DATE DECEASED OF СОШО (Type or print) DEATH 19 67 A DAMS Josephine carbon ut, withir 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED TO AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. 8. DATE OF BIRTH last birthday) and Months Dave Hours female WIDOWED [DIVORCED physician 10a. USUAL OCCUPATION (Give kind of work гетоме 10b. KIND OF BUSINESS OR INDUSTRY BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) School Teacher Maryland USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME please aftending John Adams Marv 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) | (If yes give wer or dates of service) hospital or attending physician. certificate has been signed by the Springfield Hospital Pecords INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause par line for (a), (b), end (c),] ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Bilateral pneumonia. daws IMMEDIATE CAUSE (a) the burial-transit DUE TO Conditions, if any, which gave rise to immediate couse DUF TO (e), steting the underlying burial, cause lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 19. WAS AUTOPSY CERTIFICATION 8 9 PERFORMED? NO R CBS assoc. with semile brain disease, with psychotic reaction. 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) After 20c. TIME OF INJURY 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State) Month, Dev. Yeer factory, street, office bldg., etc.) While Not While Hour a.m. at work at work 21. I certify that (I) (this hospital) attended the deceased from. 11. 22b. DATE 22a. SIGNATURE SIGNED ATTENDING MED. STAFF PHYS. DIRECTOR PITAL PAGE 4 FUNERAL 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) Julian Radzykowycz, M.D. Springfield Hospital, Sykesville, Md. director, be filed v 23d, LOCATION (City, fown or county) (State) 230. BURIAL, CREMATION, | 23b. 23c. NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) 25s. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) DATE JUL 2 5 '61 15M 9/60 arthur S. House

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24 hours ve Pages PM3. Pages 1 Pages 1	13.	FATHER'S NAME				14. MOTHER'S MAIDE					
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C.B.S. assoc. with CNS Syphilis, meningoencephalitis with psychotic										PERFO	AUTOPSY ORMED? NO •
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AMINE Writing Chief Page 3 sto buriting	-	20c. TIME OF INJU	IRY Month, Day, Year		Apparently as			y or town)	(County)		(State)
EXAMINER: ste, writing the the Chief Me R. Page 3 shorton to buriel,	MEDICAL	Hour e.m.	<u>~</u> 19	While at wor	THE PARTY OF THE P	ory, street, office bldg., office bldg.,	-	sville	Carro	511	Md.
EX.		21. I certify t	nat I took charge of	the rem	nains described above, he	ld an Autopsy X	Inspection	X Inquir	y X, and	in my c	opinion
MEDICAL the cariffic forwarded to DIRECTC		death resulted	from: Natural cau	ses 🗌	Accident X. Suic	1	-	determined m	anner [
the character war		ACTUAL)	Son a	CHIEF MEDICA	L			NEED OF	C1100
or for a for		SIGNATURE	Kines -		March	M.D.	EDICAL EXAMINER	IER _		T STE	JNED
OTY Personal designation		EXAMINER'S NAME (Type)			rsh, M.D.	Address (Stree	t, city, town, or			16	161
Specific States	220	REMOVAL (Specify	ON, 22b. DATE THEREO	1	Ellen Har	1	1 5	TION (Eity, town,	Adway	- Us	ed.
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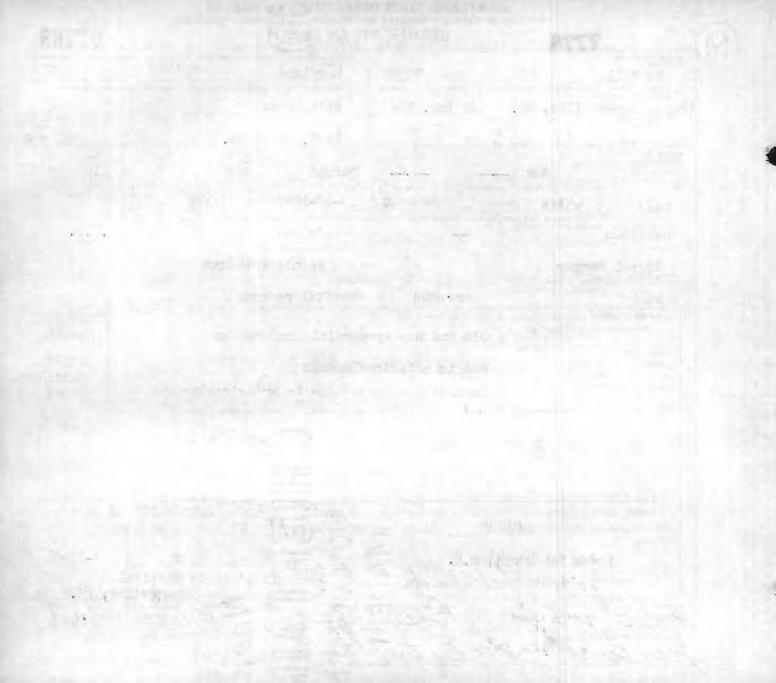
RYLAND STATE DEPARTMENT OF HEALTH

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

	7778	Then O	CERTIFICA	TE OF DEATH			07769
1. PLACE OF DEATH o. COUNTY Carroll		A VOIR	MARYLAND	2. USUAL RESIDENCE (W. STATE Maryland	here deceased lived. If in b. CO		e before admission)
b. CITY OR TOWN (IF	outside corporate lim	its, write c. LEN	NGTH OF STAY IN 16	c. CITY OR TOWN (IF	outside corporate limits, v	rite RURAL and g	ive nearest town)
(Rural) Syke		1. 47	lmo. 10d	Baltimore		3V01.	4
d. NAME OF HOSPITA	(If not'in hospitol,	give street address		d. STREET ADDRESS	++ Q+		IS RESIDENCE ON A FARM? YES NO R
NAME OF	Fi	rst	Middle	lost	4. DATE	Month	Day Year
(Type or print)	Max	-		Berger	OF DEATH	7	10 19 61
5. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	B. DATE OF BIRTH	9. AGE (In last birth	1	YEAR IF UNDER 24 HRS
male	white	WIDOWED [DIVORCED 🔀	10-18-1887	1 73/4	yrs. Months	Days Hours Min.
during most of worki Salesman	N (Give kind of working life, even if retired	done 10b. KIND (OF BUSINESS OR INDU	JSTRY 11. BIRTHPLACE (Stole Poland	or foreign country)		IN OF WHAT COUNTRY
3. FATHER'S NAME				14. MOTHER'S MAIDEN I	NAME	1	
Israel B	erger			Sophia	Friedman		
15. WAS DECEASED EVER	140	service	L SECURITY NO. 17.	Hospital rec	ords	Address	
Conditions if on gove rise to in couse (o), storing to lying couse lost.	he under-	o due Soft	to arterio	ocardial info sclerosis rain due to a t NOT RELATED TO THE TERM	rteriosclero		months years months years 1(o) 19. WAS AUTOPS: PERFORMED? YES A NO C
PART II. OTHI 20g. ACCIDENT WAS OR CONTRIBUTING (IF EITHER, NOTIFY) 20c. TIME OF INJURY Hour o. m.	CAUSE OF DEATH	ear 20d. INJURY	OCCURRED 20e. Pl	ED. (Enter noture of injury in LACE OF INJURY (Home, form octory, street, office bldg., etc	n, 20f. (City or town)		ounty) (State
21. I certify that saw the decease 220. SIGNATURE	ed alive an Ji	ashi, M.I.	hash	22d. ADDRESS Springf	M, from the cause ED STAFF IRECTOR D PHYS. D ield State I	es ond on the	7-10-61 7-10-61
230 BURIAL CREMATION REMOVAL (Specify) 24. JUNERAL DIRECTOR'S	7-14,-61	?	NAME OF CEMETERY OF	lale	D BY REGISTRAR 25b.	REGISTRAR'S SIG	MICE (Stole)
JOEK FRE	vio Me	2100 6	Sulaw	DATE	JUL 1 4 '61	arthur.	2 Kans

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RYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS - BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. COUNTY. b. COUNTY MARKINGS funeral uld be f b. CITY OR TOWN (I outside corporate limits, write c. LENGTH OF STAY IN 16 CLTY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) RURAL and give pearest Jawn) d. NAME OF HOSPITAL (If nat in haspital, give street address) STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? 25 YES NO P 4. DATE NAME OF Middle Manth Day Yea DECEASED OF DEATH (Type or print) 19 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR BACE B. DATE OF BIRTH lost bist Manths Days popers PHYSICIAN: The law requires that the death certificate be executed USUA_ OCCUPATION (Give kind at work dane 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stock or foreign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) and 72 13. FATHER'S NAME within 7 physician remove IS. WAS DECEASEDEVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. (127) INFORMANT Address attending please 1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I, DEATH WAS CAUSED BY. IMMEDIATE CAUSE (o) DUE TO Canditians, if ony, which been signed b (b) gave rise to immediate **DUE TO** couse (a), stating the underlying cause last. PART 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(D) 19 WAS ALTOPSY PERFORMED? After this certificate has YES 🖂 NO T 20a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH 206 DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL Ö 20c TIME OF INJURY Manth, Day, Year 20e. PLACE OF INJURY (Hame, form, '20f' (City or town) 20d INJURY OCCURRED (County) (State) factory, street, affice bldg, etc.) Haur o m. White Nat while at work at wark p. m. 21 I certify that (I) (this hospital) attended the deceased frage that (i) (we) last saw the deceased alive an MM, from the causes and an the date stated above and that death accurred at O FUNERAL DIRECTOR: 22a SIGNATUR ATTENDING PHYS. MED. DIRECTOR M.D. Board 22d ADDRES shmuld page 3 the Stat 23a, BURIAL CREMATION, 23b DATE THEREOF 23d LOCATION (City, town, or county) 23c. NAME QE CEMETERY OR CREMATORY (State) O HOS MOVAL (Specify) FUNERAL DIRECTOR'S SIGNATURE ADDRESS BY REGISTRAR 256. REGISTRAR'S SIGNATURE Chitting & Heneral DATE



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AND STATE DEPARTMENT OF HEALTH



1	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
	7722 CERTIFICATE OF DEATH 07773
M	1. PLACE OF DEATH • COUNTY CONTROL 2. USUAL RESIDENCE (Where decessed lived, if institution, Residence before edmission) • STATE MARYLAND MARYLAND MARYLAND MARYLAND
dead	b. CITY OR TOWN (if outside corporate limits, write RURAL end give nearest town) c. CITY OR TOWN (if outside corporate limits, write RURAL end give nearest town)
after 1	Sykesville d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) o. 15 RESIDENCE ON A FARM?
	Springfield State Hospital 3. Name of Deceased Month Deceased Mon
	5 SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In yeers last birthday) Months Deys Hours Min.
	10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 12. CITIZEN OF WHAT COUNTRY?
_	Housewife North Carolina 13. FATHER'S NAME U.S.A. 14. MOTHER'S MAIDEN NAME
I	Berkley Upchurch 15. WAS DECEASED EVER IN U.S. ARMED FORCES? , 16. SOCIAL SECURITY NO.; 17. INFORMANT Address
7	(Yes, no, or unkown) (Ifyes give were relates of service) NO Springfield Hospital Records INTERVAL BETWEEN INTERVAL BETWEEN
	PART I. DEATH WAS CAUSED BY. Gangrene, left leg 4221 Due to
	Conditions, If eny, which (b) peripheral insufficiency geve rise to immediate cause
	(e), stelling the underlying course lest. (c) arteriosclerotic cardiovascular disease. PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) 19. WAS AUTOPSY PERFORMED?
V	Chronic brain syndrome, cerebral arteriosclerosis. 20e. Accident was underlying
	20e. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 2Da. PLACE OF INJURY (Home, ferm, 20f. (City or town) (County) Hour e.m. While Not While fectory, street, office bldg., etc.) p.m. 19 et work et work
	21. I certify that (I) (this hospital) attended the deceased from 6-28- , 1961, to 7-12- , 161, that (I) (we) last saw the deceased alive on 7-12- 161, and that death occurred a6.130, and the causes and on the date stated above.
1	220. SIGNATURE Constant elel Campo MD ATTENDING MED. STAFF SIGNED 7-12-61
	NKME (Type) Agustin del Campo, M.D. Springfield Hospital, Sykesville, Md.
	230. BURIAL, CREMATION, 23b. DATE THEREOF 23c NAME OF CEMETERY OR CHIMATORY 23d. IOCATION (E.Ity, town or county) (Stote) REMOVAL (Specific) 7-14-6/ Updates County (Stote) ADDRESS AL 25e. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
1)	24 FUNERAL DIRECTOR'S SIGNATURE SADDRESS ADDRESS PRO'D BY REGISTRAR 256. REGISTRAR SASIGNATURE CARLLES A HALSEL ASSESSMENT REGISTRAR SASIGNATURE CARLLES A TESSMENT SALLES AND CARLLES A TESSMENT SALLES AND CARLLES AND CARLL



DIVISION OF STATISTICAL RESEARCH AND RECORDS -- BALTIMORE 1, MARYLAND **CERTIFICATE OF DEATH** with I director, PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY **D. STATE** b. COUNTY MARYLAND funeral auld be f CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 15 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) should the d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE OR INSTITUT ON ON & FARM? YES A NO 4. DATE 3. NAME OF First Middle Lost Day Year OF DEATH DECEASED Pages (Type or print) after death Ē DER TYEAR IF UNDER 24 HRS SEX COLOR OR RACE MARRIED NEVER MARRIED DATE OF BIRTH letely Days Hours WIDOWED DIVORCED popers. COMP 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPIACE during most of work ng I fo. event cettred) 12 CITIZEN OF WHAT COUNTRY? (State or foreign country) hours pilo pou 22 3 FATHER'S NAME MOTHER'S MA DEN'NAM COZ .⊆ pllysicean 4113 A LUMB WAS DECEMBED EVER IN U S ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address offellding please CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO á Conditions, if any, which permit (b) gave rise to immediate **DUE TO** couse (o), stoting the underlying couse lost the burial-transit has been physicie PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? YES 🗍 NO 📭 200 ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port 1 or Part 11 of (tem 18.) certificate OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, 20e. PLACE OF INJURY (Home, form, 20f (City or town) 20d INJURY OCCURRED (State) Doy, Year (County) factory, street, office bldg., etc.) Haur a m. Nat while While at wark of work p. m 2) I certify that (1) (this hospital) attended the deceased fram. that (!) (wa) last saw the deceased alive the and that debth accurred at causas and on the date stated above IIIECTOR: 225 DATE SIGNED ATTENDING PHYS. MD. DIRECTOR PHYS remained 22d ADDRESS should 22c PHYSICIA NAME (Type) NUNERAL 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d, LOCATION (State) page the Sta REMOVAL (Specify) EUNERAL DIRECTOR'S SIGNATURE ADDRESS 250 REC'D BY REGISTRAR SIGNATURE Chilan & Thousa DATE JUL 12 VR A15 (4) 1SM 9/S9

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MARYLAND STATE DEPARTMENT OF HEALTH

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 7784 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before edmission) e. COUNTY Balto, City the MARYLAND Carroll b. CITY OR TOWN (if culside corporale limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give neerest .own) Write RURAL and give nearest town) byrs.lmo.16day Baltimore Sykesville d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) e. IS RES DENCI ON A FARM? YES NO Springfield State Hospital Broadway and Fairmount Avenue 3. NAME OF 4. DATE DECEASED OF (Type or print) DeWalden DEATH July 1.7 1961 Chancellor Grace 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In yeers , IF UNDER 1 YEAR ! last b rihdey) Months Days DIVORCED July 6, 1865 Female WIDOWED IN 10a. USUAL OCCUPATION [Give kind of work 10b KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) U.S.A. Maryland Housewife 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Addis W. Smith Arthur Smith 15. WAS DECEASED EYER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) | (Ifyes give war or dates of service) Springfield Hospital Records 18. CAUSE OF DEATH |Enter only one cause per line for (e), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: months weeks IMMEDIATE CAUSE (a) Uremia Coma DUE TO (b) Renal insufficiency Years Conditions, if any, which gave rise to immediate cause DUE TO (a), stating the underlying PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I ... 19. WAS AUTOPSY C.B.S. associated with circulatory disturbance, with cerebral arterio-20a, ACC. DENT WAS UNDERLYING LT 20b DESCRIBE HOW INJURY OCCURED (Enter nature o injury in Part I or Part I, of Item 18) OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, 20f. (City or lown) (County) factory, street, office bldg , etc.) While Not While at work at work 224. SIGNATURE ATTENDING DIRECTOR PHYS. 22c. PHYSICIAN'S 22d. ADDRESS Julian Radzykewycz, M.D. Springfield Hospital, Sykesvilles, Md. 236. BURIAL, CREMATION, 236. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City, town or county) (State) REMOVAL (Specify) 0.58 BURIAL Woodlawn Cemetery Woodlawn . Md 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** VR A15 (4) DATE JUL 1 8 '61 Cirthur & thank 15M 9/60 Wm. Cook, Inc., 1217 St. Paul Street

DEPARTMENT OF HEALTH



Division of STATISTICAL RESEARCH AND RECORDS. 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE 0 Film G202 8/ 7. TRUAL RESIDENCE (Where deceased lived, If Institution, Residence before edmission) . PLACE OF DEATH . COUNTY a. STATE b. COUNTY Michigan Carroll is necessary MARYLAND b. CITY OR TOWN (If outside corporete limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corporate limits, write RURAL and give necrest town) director. write RURAL and give negrest town? Detroi t Westminister d, NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS 4. IS RESIDENCE for ON A FARM? YES NO Clearview Motel State Ashton 3. NAME OF Middle 4. DATE Day Month DECEASED OF (Type or print) DEATH CLINGAN AUGUSTA 19 61 BERNARD July 8, DATE OF BIRTH IF UNDER I YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 7. MARRIED TO NEVER MARRIED 9. AGE (In years) last birthday) Months Hours WIDOWED DIVORCED Male 10a. USJAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? uring most of working life, even if retired) FATHER'S NAME 13. D. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 16 SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) | (If yes give wer or detect for vice) 18. CAUSE OF DEATH |Enter only one cause per line for (e), (b), and (c), INTERVAL BETW ONSET AND DEATH IMMEDIATE CAUSE IN Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which [b] pave rise to immediate cause DUE TO (e), stating the underlying PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISFASE CONDITION GIVEN IN PART II.) 19. WAS ALTOPSY PERFORMED? NO F D 20s, EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED, lEnter nature of injury in Part I or Part If of Item 18.) PRIMARY OF CONTRIBUTING CAUSE OF DEATH. 20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 1 20f. (City or town) (County) (Steta) factory, street, office bldg., etc.) While Not While Hour e.m. et work et work 21. I certify that I took charge of the remains described above, held an Autopsy X Inquiry and in my opinion Inspection Ö DIRECT(Undetermined manner death resulted from: Natural causes Accident Suicide Homicide forwar CHIEF MEDICAL EXAMINER ACTUAL DATE SIGNED should be for SIGNATURE DEPUTATION EDITIONS EXPENDING TO DEPUTATION OF THE PROPERTY OF Reter W. Rieckert, M.D. NAME (Type) Address (Street, city, town, or county) 224. NAME OF CEMETERY OR CREMATORY 224, BURJAL, CREMATION. 22d. LOCATION (City, town, or country) (State) **IEMOVAL** (Specify) 40 g REC'D BY REGISTRAR 1 24b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR VS. A15ME 5M 9/60

STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



DIVISION OF STATISTICAL RESEARCH AND RECORDS - BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH director, 2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission 1 PLACE OF DEATH a COUNTY b. COUNTY MARYLAND Marvland Balto. Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ō b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 9 RURA, and give negrest town) lyr.3mos.16days Baltimore Svkesville e IS RESIDENCE d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS ON A FARM? YES NO E 7913 Elmhurst Avenue Springfield State Hospital 4. DATE NAME OF Middle Month Day Yeor DECEASED Elizabeth DEATH July (Type or print) Sarah Cole 19 6 9. AGE (In years F JINDER I YEAR IF UNDER 24 HRS 5 SEX 6. COLOR OR RACE / MARRIED NEVER MARRIED B. DATE OF BIRTH last b rthdoy) Months Days DIVORCED [May 27, 1880 Female White WIDOWED TO 10a. USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Housewife Texas II.S.A 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Spencer Warren Maggie White 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address No Springfield Hospital Records INTERVAL BETWEEN 1B. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c),] ONSET AND DEATH Bronchopneumonia with lung abscess days DUE TO Rheumatic heart disease Conditions, if any, which Vears gave rise to immediate DUE TO couse (a), stating the underlying couse lost uriol-tronsit PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY cremotion, DSVChoticeRFORMED? YES TO NO Chronic Brain Syndrome associated with senile brain disease reaction 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b, DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18) CERT Month, Day, Year 20e PLACE OF INJURY (Home, form, 20f (City or town) 20c. TIME OF INJURY 20d INJURY OCCURRED (County) (Stote) foctory, street, office bldg , etc.) Hour a m. While Not while at work at work p. m 21. I certify that (1) (this haspital) attended the deceased from March 19, 1860, to July 5, ..., 1961, that (1) (we) last 1961, and that death accurred at 9200, from the causes and an the date stated above saw the deceased alive an July 5. 22a, SIGNATUS ATTENDING MED DIRECTOR DIRECT M D should 22c PHYSICIAN 22d. ADDRESS NAME (Type Springfield Hospital, Sykesville, Md. Campo M. D. Agustin de FUNER BUR.AL CREMATION 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City, lown, or County) REMOVAL (Specify) 0 24 FUMERAL DIRECTOR'S SIGNATURE 25g. REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE **ADDRESS** Cothur & Kraus TSM 9/59

AND STATE DEPARTMENT OF HEALTH



AND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

7729

67779

1. PLACE OF DEATH o. COUNTY Carr	011		MARYLA		o. STATE Mary 1	here decease and	ed lived. If insti b. COUN	JTV _	roll	ssion)
b. CITY OR TOWN (II	outside carparate limi	ts write c	LENGTH OF STAY IN	16	c CITY OR TOWN (IF	autside corp	orote limits, writ	te RURAL and g	eve nearest to	vn)
Rural, West	inster		75 Years]]	Rural, West	minste	er	.ere		
d NAME OF HOSPIT. OR INST TUTION	AL (If not in hospital, g	jive street add	dress)		d. STREET ADDRESS			1	. ON	SIDENCE A FARM?
Westminster				W	estminster,				Ls) YES [NO (1)
3 NAME OF DECEASED (Type or print)	Mary	rat	Middle Anna.		Crow1	4. DATE OF DEATH		Month uly	19 ·	Year 19 61
S SEX	6 COLOR OR RACE	7. MARRIEL	DENEVER MARRIED	□ B C	PATE OF BIRTH		9. AGE (In yellost birthdo		TYEAR IF UN	
Female	White	WIDOWED	DIVORCED	DIVORCED AT		3		yrs. Months	Doys Hour	Min.
10a. USUAL OCCUPATIO	N (Give kind of work	done 10b. Kli	ND OF BUSINESS OR	INDUSTR'	11. BIRTHPLACE (Stot	e or foreign	country)	12.CITI	ZEN OF WHAT	COUNTRY?
Housewife-	ing`life, even if retured LOUSEWOTK	Her	own home		Lancaste	r Co.	Pa.	บ.	S.A.	
13. FATHER'S NAME				1	4. MOTHER'S MATERI	Zabe tl	h			
Austin N	lyers				Metzlxe	r	(I	lizabet	th Metz	lxer)
15 WAS DECEASED EVE			OCIAL SECURITY NO	17 INFO	RMANT		,	Address		
No. or unknown)	If yes, give war or dates of s		0-03-2908A	Gar	field D. Cr	owl, i	Westmins	ster, Mo	1. R. D	. 2
18. CAUSE OF DEA	TH [Enter only one co	ouse per line	for (a), (b), and (c)]	2					INTERVAL	
PART I DEA	TH WAS CAUSED BY. IMMEDIATE CAUSE (c	,,	Encha		Homow	wer.			91	aus
	DUE TO)		_		0				
Conditions, if o	ny, which) a	. Hu	rection in	s Car	rdio-Vol	cula	n Illes	RAZR	101	sears
gave rise to it couse (a), stating		3	1							J
lying couse lost.) (a	:)								
PART 11. OTH	IER SIGNIFICANT CON	IDITIONS CO	NTRIBUTING TO DEAT	H BUT NO	T RELATED TO THE TER	MINAL DISEA	SE CONDITION	GIVEN IN PAR	T 1(o) 19 WA	S AUTOPSY FORMED?
CATI									YES [_
	S UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)	20b. DESCR	IBE HOW INJURY OCC	CURRED (Enter nature of injury i	n Port I or Po	ort II of item 18	1		
Z 20c. TIME OF INJUR	Y Month, Doy, Ye	ar 20d, INU	URY OCCURRED 20		OF INJURY (Home, fa		ty or town)		County)	(Stote)
20c. TIME OF INJUR Hour o. m.	19	While of work	Not while	foctor	y, street, office bldg., e	le.)				
	- 215 25E2 - 1 25 -			To-	1011/2) ,	of la	644/4	19 10/5		t
		() attended	d the deceased fr	ramLt.	th accurred of		- Joseph 1			
saw the deceas	ed alive an	Viz -	17,421, and the	nat dea	in accurred on 12	M, fran	n the causes	and an the		22b. DATE
220 3 SINA GRE	RR	(10	tter	М.		MED. DIRECTOR E	STAFF PHYS	0	July 16	SIGNED
22c. PHYSICIAN'S NAME (Type)	L.L.	POT	TER M	· D	22d ADDRESS	TTL	EST	own	PA	
23a BURIAL, CREMATIC REMOVAL (Specify)		OF	23c, NAME OF CEMET	ERY OR C	REMATORY	23d. LOC	ATION (City, to	wn, or county)	(5	rote)
Burial	7/22/61		St. Marys	Ceme		Si1			11 Co.	Md
24 FUTGERAL DIRECTOR	S SIGNATURE	5.0	ADDRESS	2		C'D BY REGI	2 100	REGISTRAR'S SIG		
Kickena	A. di	the.	dittes	tow	n/ DATE!	11 2 4 7	61	Tillun S.	/ Water	

VR A1S (4) 15M 9/59



VR A15 (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 7789

07780

1	1. PLACE OF DEATH o COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)							
Λ	CARROLL	MARYLAND	MARULAND 6. COUNTY							
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
	KURAL SUKESUILLE	12 dA48 1	HURA! MI. AIRY							
	d. NAME OF HOSPITAL (If not in hospital, give street of OR INSTITUTION	address)	e. IS RESIDENCE ON A FARM							
	Colden Age Guest	Home	K. D # 2, YES NO	2						
5	3. NAME OF DECEASED	Middle	DANAS 4. DATE Month Day Year							
	(Type or print) Goldia	11.	DEATH HULL 23, 196	E						
	S SEX 6 COLOR OR RACE 7 MARR		3. DATE OF BIRTH AGE (IN years IF UNDER 1 YEAR IF UNDER 24 Hours Manths Days Hours Ma							
	Female white WIDOWE		11-15-28 72 ys							
	100. USUAL OCCUPATION (Give kind of work done 10b. during most of working life, even if retired)	KIND OF BUSINESS OR INDUS	TRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNT	'RY?						
/	Housewife V	lo singuestic.	111ARY 14NA U.S							
	13 FATHER'S NAME	,	14. MOTHER'S MAIDEN NAME							
	Nev, FR122E11	To the second se	Vinginia .							
	15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 (Yes, no or unknown) [If yes, give war or dates of service)	SOCIAL SECURITY NO 17. IN	Address Address 1) D co 131 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	, 1						
	No	///	E, HT/20 C. DAVIS, K-U, 2.1/171.141Ky, MI	<u>q</u>						
	18. CAUSE OF DEATH (Enter anty one couse per tin PART I. DEATH WAS CAUSED 8Y:	ne for (o), (b), and (o).	INTERVAL BETWEE	H						
	IMMEDIATE CAUSE (6)									
	DUE TO	n.	No total							
	Conditions if any, which (b)	ancen	ma of sueseen ayou	-						
	couse (a), stating the <u>under-</u> lying couse last.									
	, 101	ONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOL	PSY						
	PART II. OTHER SIGNIFICANT CONDITIONS C		PERFORMED YES NO	M						
	TO ACCIDENT WAS UNDERLYING TO JOB DESC	CRIBE HOW INJURY OCCURRE). (Enter nature of injury in Part I or Part II of item 18)							
	OR CONTRIBUTING CAUSE OF DEATH									
		NJURY OCCURRED 20e. PL	CE OF INJURY (Home, farm, 20f (City or tawn) (County) (SI	late)						
	Hour o.m. P. m While at ward		tary, street, affice bldg., etc.)							
	21. I certify that (1) (this haspital) attend	led the deceased from 6	Short 10 19 41 0 to belle 2 3, 19 (al, that (1) (we)	last						
	saw the deceased alive and 2.2.3.		eath accurred and M, from the causes and on the date stated abo							
	276 SIGNATURE 0/01	4	226 DAT							
	Minule 1 / Mais	elen	A.D. PHYS MED DIRECTOR C, PHYS C SCI 423/9	6/						
	PHYSICIAN'S NAME (Type)	Much has	22d ADDRESS	7						
	1110 RRE11. 11.	/ //HSTIN, ITH) & speenle ma							
	23a, BUR AL, CREMATION 23b. DATE THEREOF	23c NAME OF CEMETERY O	2 1 13 1 1 2							
	LECO 1961 July - 26-1961	Winted Church n	God Cometely CARROLL (10. //INRYland							
	24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS MAN	25a. REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE							
	C.111. 66 6172, 6611	MTIELC, ///FR	14/Anc DANS 2161 Critica S. Trans							



ours after death. Page 4 the funeral dimetar, shauld be filed with ain by may it, revained by the haspital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filted manages 3 should be detacted for use as the burial-transit permit. Then please remaye carbon papers. Pages 1 the State Board of seath within 72 hours after death the State Board of seath within 72 hours after death OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

MARYLAND STATE DEPARTMENT OF HEALTH

		7790	ON OF			TE OF DEATH		, MARY	LAND		0'	778	31		
1.	PLACE OF DEATH					2. USUAL RESIDENCE (V	Vhere dece			n: Residen	ce befo	re odmi	ission)		
	Carro	011		NAME OF TAXABLE PARTY.	CNING	a. STATE Marvla	nd	ŀ	b. COUNTY	Carro	11				
	b. CITY OR TOWN (IF RURAL and give nea		s, write	c. LENGTH OF STAY	IN 1b			rporate lin		IRAL and give nearest (Own)					
	Taneytown			L YEAR		Taneyt	own								
	 d. NAME ÖF HOSPITA OR INSTITUTION 	it (If not in haspital, g	ive street	address)		d. STREET ADDRESS						ON	SIDENCE A FARM?		
	2	2 W. Baltin	nore	Street		22 W. B	altim	ore S	Street]	YES [NO		
3.	NAME OF DECEASED	Fire	ıt	Middle		Lost	4. DAT	E	Mantl	h	Da	у	Year		
	(Type or print)	Elsi		Bel	le	Dutrow		OF DEATH .Tilly			1/.				
5.	SEX	6. COLOR OR RACE	7. MARR	IED NEVER MARRIE	D	B. DATE OF BIRTH			E (In years birthday)						
	Female	White	WIDOWE	DIVORCE		Tuly 11 188	1.	77	y yrs	Manths	Days	Haur	Min		
	USUAL OCCUPATION	N (Give kind af wark on ng life, even if retired)	lane 10b.	KIND OF BUSINESS O	RINDUS	TRY 11. BIRTHPLACE (Stat	e ar foreig	country)	-	12. CIT	ZEN OF	WHAT	COUNTR		
	Housework		Юw	n home		Maryland				U.	S.A				
13.	FATHER'S NAME					14. MOTHER'S MAIDEN	NAME								
L	Elias Sing					Unknown									
	WAS DECEASED EVER	IN U. S. ARMED FOR		SOCIAL SECURITY NO	17, IN	FORMANT			Addre	255					
Ĺ	No			20-26-5668	Mr	s. Myrle Dev	ilhis	s. T	anevto	wn. l	larv	lan	3		
	18. CAUSE OF DEAT	H [Enter anly one ca	se per lir	e far (a), (b), and (c).		4 -		4	,		INTE	RVAL E	ETWEEN		
	PART I. DEAT	H WAS CAUSED BY, IMMEDIATE CAUSE (a)	ac	utela	roc	under	lung	. Ce	clu	sery	7	EL AN	MI		
	470	DUE TO	200				1			9					
	Canditions, if an	y, which)	Pla	M 20 1 21		Interior	2000				154				
	gave rise to im				1				1				1		
	cause (a), stating the lying cause lost.	(c)	10	leur	al	end li	rele	un	reche	and a	1	15	ye		
Z	PART IL OTHE	R SIGNIFICANT CON	DITIONS C	ONTRIBUTING TO DEA	TH BLT	NOT RECOVED TO THE TERM	MINAL DISE	ASE CON	DITION GIVE	N IN PAR	T 1(a) 1	9. WAS	ORMED?		
CATE												YES [
CERTIFICATION	20g. ACCIDENT WAS OR CONTRIBUTING I (IF EITHER, NOTIFY A	UNDERLYING DEATH	20b. DESC	CRIBE HOW INJURY OF	COURRED). (Enter nature of injury in	Part I or I	Part II of i	item 18)						
MEDICAL	20c. TIME OF INJURY Hour a.m. p. m	Month, Day, Yea	7 20d. It While at warl	NJURY OCCURRED Nat while at wark		CE OF INJURY (Hame, far tary, street, affice bldg., e		ity or tax	vn)	(4	County)		(Stal		
	21 I certify that	(I) (this haspital	attend	ed the deceased	fram	10/29	946 10	7/	14	, 194	2/. th	at (I)	(we) la		
	saw the decease	ed alive on	14	1960 J. and	that d	eath accurred at 2	N. fra	m the c	auses and	on the	e date	state	d abov		
	22a SIGNATURE	1.1.74	·Va	xuel		ATTENDING	MED. DIRECTOR	STA	FF				2b. DATE SIGNE		
	22c PHYS CIAN'S	787		1.	Pi	22d. ADDRESS	- NECTOR	FH1	3 📙		-				
	NAME (Type)	2.5. M	0110	2 weeks		1	211	1	Care .			24	-		

23a BURIAL, CREMATION REMOVAL (Specify) Burial 23c NAME OF CEMETERY OR CREMATORY DATE THEREOF

24 FUNERAL DIRECTOR'S SIGNATURE C.O. FUSS & Son

(City tawn, ar caunty)

(State)

Keysville Cemetery
ADDRESS Keysville, Carroll, Maryland 256 REGISTRAR'S SIGNATURE 25a. REC'D BY REGISTRAR

Taneytown, Maryland DATE 111 1 7 '61 Citima S. Hrank

VR A15 (4) 15M II/59

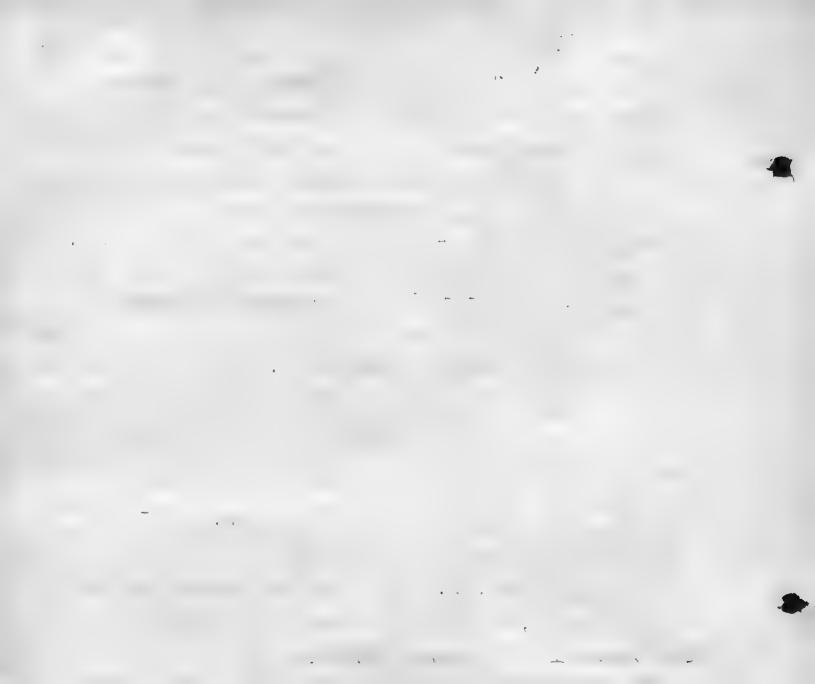


Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 770 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased I vad, If institution, Residence before admission) I. PLACE OF DEATH a. COUNTY b. COUNTY dot Health, funeral director. Page MARYLAND Carroll lary land b, CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give neerest town) write RURAL and give neerest lown) d. NAME OF HOSPITAL OR INSTITUTION (IF not in hospital, give street address) Baatimore Boar e. IS RESIDENCE ON A FARM? YES NOT Springfield State Hospital 3. NAME OF Midde DECEASED OF DEATH (Type or print) 1961 Connage F. w:th 8. DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX 2 wit M3. Page 5 may M3. Page 5 may pages 1 and 2 wit within 72 hours a last birthday) Months Davs Hours WIDOWED T DIVORCED KQ female 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? dona during most of working life, even if refired) File pages I Virginia W.S.A. Telephone operator P.M.3. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Give John A. Ferguson Margaret Lackey WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT (Yes, no, or unknown) | (Ifyes give war or dates of service) Office along with fit a burial-transit permit Springfield Hospital Records 18. CAUSE OF DEATH [Entar only one cause per line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: "weardial infarction. minumis IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which (b) gave rise to immediate cause "peniling" eg the word "penaling of Medical Examiner's 3 should be used will, creaminery DUE TO (a), stating the underlying PART II OTHER'S GN FICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? CRS assoc. with Alzheimer's Disease NO 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of Injury in Part I or Part II of item 18.) PRIMARY | or CONTRIBUTING | ease execute the certificate, writing the should be forwarded to the Chief Marchard DIRECTOR: Page 3 shreats designated agent, prior to burial, MEDICAL 20d, INJURY OCCURRED | 20e. PLACE OF INJURY (Homa, form, ; 20f. (City or town) 20c. TIME OF INJURY Month, Dey, Year (County) (Stata) factory, street, office bldg., atc.) Whila Not While Hour s.m. at work - at work -21. I certify that I took charge of the remains described above, Held an Autopsy Inspection Inquiry and in my opinion Undetermined manner Accident Sulcide Homicide death resulted from. Natural causes | -CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER DATE SIGNED SIGNATURE DEPUTY MEDICAL EXAMINER EXAMINER'A NAME (Type) James T. Marsh. Address (Streat, city, town, or county) 22a. BURIAL, GREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, lown, or country) REMOYAL (Specify) Burial Woodlawn Cemetery ₽40 Baltimore 24a. REC'D BY REGISTRAR I 24b. REGISTRAR'S SIGNATURE 23. FUNERAL DIRECTOR VS. A15ME mopping and Kirkleym Glen Burnie, Md. L remy L. Through 5M 7/59

YLAND STATE DEPARTMENT OF HEALTH



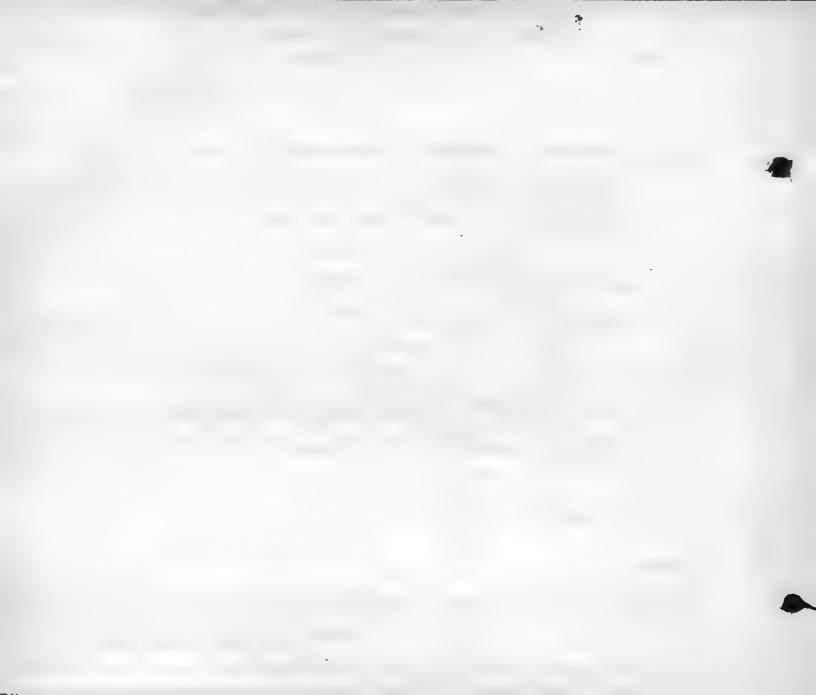
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		7 / 1 2
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS d. STREET ADDRESS	0. 15 RE
	Springfield State Hospital 20 Belview Avenue	YES 📋
	3. NAME OF First Middle Last 4. DATE Month OF	Day Year
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	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years last birthday) Mc	UNDER 1 YEAR IF UNDER
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	Housewife Pennsylvania	U.S.A.
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إث	William Bryan 15. WAS DECEASED EYER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT Address	
	(Yes, no, or unknown) (Hyesgivewerordetesofservice)	
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	Conditions, if eny, which (b) Acute and chronic nephritis.	Days an
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	Chronic brain syndrome, senile brain disease.	
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1 1	MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
FOR STATE	779MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No. 07784
HEALTH DEPT.	1. PLACE OF DEATH o. COUNTY MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE M. C b. COUNTY
of files	b. CITY OR TOWN (I outside corporate timits, write RURAL and give nearest town) and any feather than the state of the stat
Board dire	o NAME OF HOSPITAL OF INSTITUTION APPROACH SIVE street address) of NAME OF HOSPITAL OF INSTITUTION APPROACH SIVE street address) of NAME OF HOSPITAL OF INSTITUTION APPROACH SIVE STREET ADDRESS of NAME OF HOSPITAL OF INSTITUTION APPROACH SIVE STREET ADDRESS of NAME OF HOSPITAL OF INSTITUTION APPROACH SIVE STREET ADDRESS of NAME OF HOSPITAL OF INSTITUTION APPROACH SIVE STREET ADDRESS of NAME OF HOSPITAL OF INSTITUTION APPROACH SIVE STREET ADDRESS of NAME OF HOSPITAL OF INSTITUTION APPROACH SIVE STREET ADDRESS of NAME OF HOSPITAL OF INSTITUTION APPROACH SIVE STREET ADDRESS of NAME OF HOSPITAL OF INSTITUTION APPROACH SIVE STREET ADDRESS of NAME OF HOSPITAL OF INSTITUTION APPROACH SIVE STREET ADDRESS of NAME OF HOSPITAL OF INSTITUTION APPROACH SIVE STREET ADDRESS of NAME OF HOSPITAL OF INSTITUTION APPROACH SIVE STREET ADDRESS of NAME OF HOSPITAL OF INSTITUTION APPROACH SIVE STREET ADDRESS of NAME OF HOSPITAL OF INSTITUTION APPROACH SIVE STREET ADDRESS of NAME OF HOSPITAL OF INSTITUTION APPROACH SIVE STREET ADDRESS of NAME OF HOSPITAL OF INSTITUTION APPROACH SIVE STREET ADDRESS of NAME OF HOSPITAL OF INSTITUTION APPROACH SIVE STREET ADDRESS of NAME OF HOSPITAL OF INSTITUTION APPROACH SIVE STREET ADDRESS of NAME OF HOSPITAL OF INSTITUTION APPROACH SIVE STREET ADDRESS of NAME OF HOSPITAL OF INSTITUTION APPROACH SIVE STREET ADDRESS of NAME OF HOSPITAL OF INSTITUTION APPROACH SIVE STREET ADDRESS of NAME OF HOSPITAL OF INSTITUTION APPROACH SIVE STREET ADDRESS of NAME OF HOSPITAL OF INSTITUTION APPROACH SIVE STREET ADDRESS of NAME OF HOSPITAL OF INSTITUTION APPROACH SIVE STREET ADDRESS of NAME OF HOSPITAL OF INSTITUTION APPROACH SIVE STREET ADDRESS of NAME OF THE
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T SEE TO	5. SEX 6. COLOR OF RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In your lost bightdown) Northern Days Hours Min.
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Poges 1	13. FATHER'S NAME / ALC REALES 14. MOTHER'S MAIDEN NAME
Give in file ony evy	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT (You no or uning day) (If yes, give wor or dates of service) (If yes, give wor or dates of service)
I permit and in	18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) A C C C C C C C C C C C C C C C C C C
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a bunda	gove rise to immediate cause (a), stating the underlying couse last. (c)
al Exan	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPSY PERFORMED? YES NO 127
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ed to the	21. I certify that I took charge of the remains described above, held on Autopsy, Inspection K. Inquiry, and in my opinion death resulted from: Natural causes, Accident K. Suicide, Hamicide, Undetermined manner
rifificate prwords RECTO sed age	ACTUAL SIGNATURE WE LEVE OR CICLES MD CHIEF MEDICAL EXAMINER [] DATE SIGNED
d be resigned	EXAMINER'S NAME (Type) W.C.I. F. V.N. S.D.F.I.C. H. F.R. GECCHEROL EXAMINER (TYPE)
A thou	220. BURIAL CHEMATION, 22b. DATE THEREOF . 22c. NAME OF CEMETERY OR CHEMATORY 27d LOCATION (City, town, or county) (Stote)
5. A15ME 5M 2/57	23. JUNERAL DIRECTOR'S SIGNATURE 240. REC'D BY REGISTRAR 246. REGISTRAR'S SIGNATURE DATE HH 5 161
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7794 **CERTIFICATE OF DEATH** Rea, Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission o. COUNTY filed b. COUNTY MARYLAND ero b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) pe RURAL and give peacest town) should e. IS RESIDENCE 0 YES THE NO F NAME OF First Middle 4. DATE Year Month DECEASED (Type or print) DEATH 196 6. COLOR OR RACE 7. MARRIED THE NEVER MARRIED 9. AGE (In years last bythdoy) IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours WIDOWED IT DIVORCED [100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME IS. WAS DECEASEDEVER IN U.S. ARMED FORCES? 16, SOCIAL SECURITY NO. 17. INFORMANT Address 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY:
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Maryland

Waltz

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Days

(County)

e. IS RESIDENCE

Hours

INTERVAL BETWEEN

ONSET AND DEATH

WAS AUTOPSY

(Stote)

PERFORMED? YES NO NO

f_, that (1) (we) last

(Stote)

ON A FARM?

YES | NO DE

Year



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institut on, Residence before admission) a. COUNTY b. COUNTY by the and 2 death. Carroll MARYLAND Balto, City Maryland b. CITY OR TOWN (if oulside corporate limits, c. LENGTH OF STAY IN 15 c. CITY OR TOWN (If outside corporate limits, write RURAL and give neerast town) write RURAL end give neerest town) Sykesville Baltimore 13 wears. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? 1139 Homestead Street YES NO TO Springfield State Hospital 3. NAME OF 4. DATE DECEASED OF (Type or print) Louise Griffin DEATH Marv 19 67 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX 8. DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months | Days Female White WIDOWED TO DIVORCED -December 23, 1869 10a. USUAL OCCUPATION (Giva kind of work 10b. KIND OF BUSINESS OR INDUSTRY II. BIRTHPLACE (County & Siete, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) Housewife Marvland U.S.A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME John Milway Sarah Ann 15. WAS DECEASED EYER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) ((Ifyas give wer or detes of service) No Springfield Hospital Records 18. CAUSE OF DEATH [Enter only one cause per line for [e], [b], and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED 8Y: Septic embolism with gangrene of left leg. IMMEDIATE CAUSE (e) 2 days DUE TO Conditions, If any, which geve rise to Immediata cause **DUE TO** (a), steting the underlying cause lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN N PART 1.31 19. WAS AUTOPSY C.B.S. associated with disturbance of metabolism, growth or nutrition with senile brain disease, with psychotic reaction.

PERFORMED TYPES \(\text{NOTE} \)

NO \(\text{NOTE} \) 206. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of 'njury in Pert I or Part II of item 18.) MEDICAL (County) (State) 20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED 2De. PLACE OF INJURY (Home, farm, 1 20f. (City or town) While Not While factory, street, office bldg., etc.) Hour e.m. at work el work 21. I certify that (I) (this hospital) attended the deceased from 5/28/56. ./61...... 19...... that (I) (we) last M. From the causes and on the date stated above.19.6.L.., and that death occured at saw the deceased alive on..... ATTENDING STAFF SIGNED DIRECTOR PHYS. FUNERAL 22d. ADDRESS 722c. PHYSICIAN'S Julian Radzykewycz, M.D. Springfield Hospital, Sykesville, Md. 23a. BURIAL, CREMATION, | 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY REMOXAL (Specify) 0 5 2 24 FUNERAL DIRECTOR'S SIGNATURE 25s. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 [4] DATE JUL 2 6 15M 9/60 Circling S. Thous



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viel viill apers. Pag 72 hours	Springfield State Hospital 3. Name of Deceased Springfield State Hospital Hanover Street Month Dey Year	
d comp	5. SEX 6 COLOR OR RACE 7, MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HR.	
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The law requires altending physicial as been signed by burial-transit permial, cremation, or relations or remation.	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia O53.4 DUE TO Conditions, if any, which gove rise to immediate cause (a), steling the underlying cause last.	_
VSICIAN: hospital or certificate h use as the vior to bur	PART II. OTHER SIGN. FICANT CONDIT ONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT, ON G VEN IN PART I(a) 19. WAS AUTOPS PERFORMED? Psychosis with convulsive disorder, epileptic deterioration. YES NO	-
IDING PH ned by the After this (letached for of Health p	20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTTEY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour e.m. 9 While Not While et work 19 et work 19 testory, street, office bldg., etc.)	
SA ATTEN ay be retain IRECTOR: should be de-	21. I certify that (I) (this hospital) attended the deceased from	ve.
PITAL C	226. PHYSICIAN'S NAME (Type) Julian Radzykewycz, M.D. PHYS. DIRECTOR PHYS. The PHYS	
direction Figure 1	230. BUBIAL CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or country) (State) REMOVAL (Specify) 7-26.61 24m ana sumy Board Business Und	
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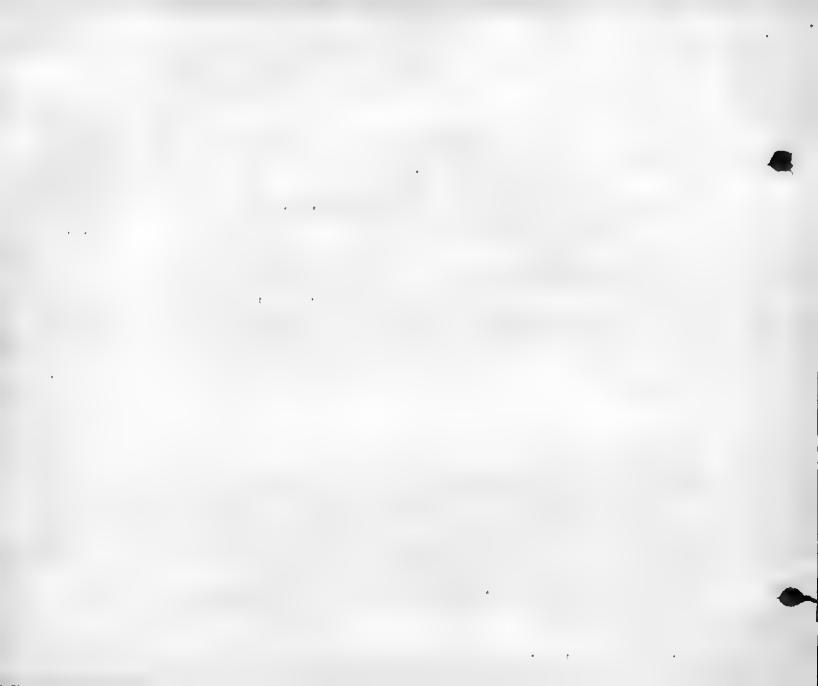
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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VS A15 (4) 15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **CERTIFICATE OF DEATH** 7799 Reg. Dist. No. director, PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) COUNTY 6. COUNTY be filed MARYLAND funeral b CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 CITY OR TOWN (If outside corperate limits, write RURAL and give nearest town) RURAL and give nearest town should d. NAME OF HOSPITAL (If not in hospital, OR INSTITUTION give street oddress) d. STREET ADDRESS IS RESIDENCE ON A FARM? 25 YES 🖬 NO 🗍 4. DATE OF DEATH NAME OF First -Middle Day Year fille (Type or print) oges, 5 SEX 9. AGE (In years lost buthday) IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 1. MARRIED W NEVER MARRIED 8. DATE OF BIRTH campletely Months Doys Hours WIDOWED | DIVORCED | 10a. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? during-most of working life, even if retired) puo WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMAN attending | -505 0 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I, DEATH WAS CAUSED BY IMMEDIATE CAUSE (o' DUE TO Conditions, if ony, which gned gove rise to immediate DUE TO couse (a), stating the underlying couse lost borial-transit PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO T 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stole) factory, street, office bldg., etc.) Hour a. m While Not while at work at work p. m. 21. I certify that I attended the deceased fram that I last saw the deceased detoched and that death accurred at 415 _M, fram the causes and an the date stated above. may be Vetained by the O FUNERAL DIRECTOR: ADDRESS (Street, city or town, stote) **DATE SIGNED** ACTUAL pe prior Hampstead.Md. AL OR SIGNATURE 3 shauld PHYSICIAN'S M. C. Porterfield NAME (Type) 220 BURIAL CREMATION. 22b. DATE THEREOF 22d. LOCATION (City, town, or county) NAME OF CEMBTERY OR CREMATORY (State) poge REMOVAL*(Specifi 24b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR'S SIGNATURE VS A15 (4) arthur S. Haus. 15M 9/58



ILOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

urs ofter death. Page 4

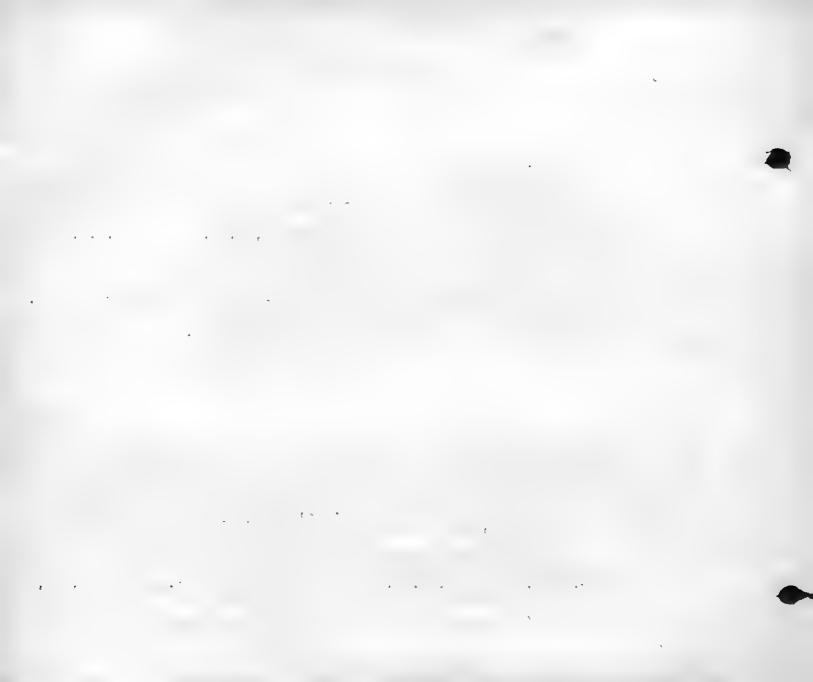
MARYLAND STATE DEPARTMENT OF HEALTH

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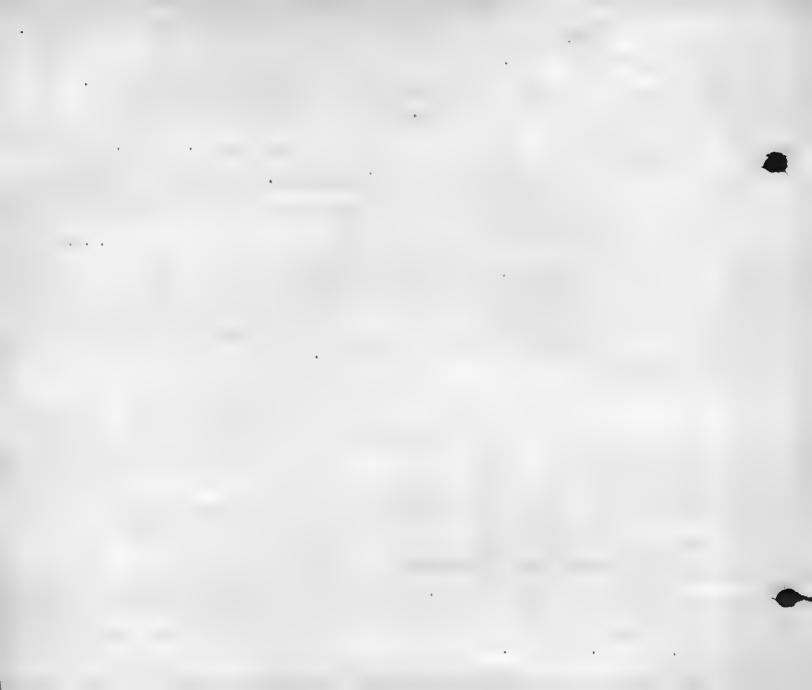
DIVISION OF STATISTICAL RESEARCH AND RECORDS -- BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

07791

	PLACE OF DEATH COUNTY Carroll			MARY	LAND	2. USUAL RESIDENCE (W o. STATE Maryland		first tot o	r Residence		ssion)			
	B CITY OR TOWN (IF	autside corporate limi	ls, write	c. LENGTH OF STAY	IN 1b	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)								
1	RURAL and give ned Henryton	orest town)		1.301 day	8	Baltimore >\(()								
1	d. NAME OF HOSPITA	AL (If nat in hospital, g	ive street	address)		d. STREET ADDRESS				e. IS RI	ESIDENCE A FARM?			
1		State Ho	spita	al		1704 Rut	land Avenu	ae .			NO 5			
3.	NAME OF DECEASED	Fir		Middle		Lost	4. DATE OF	Mont		Day	Yeor			
	(Type or print)		lian			arrington	DEATH	Ju.		6,	1961			
5 5	SEX	6. COLOR OR RACE	7. MARI	RIED 🔲 NEVER MARRIE	ED 🔲 B.	DATE OF BIRTH	9-15 9. AGE	In years irthday)	Months Do	YEAR IF UNI	7			
	Female	Negro	WIDOW	ED TO DIVORCE		?-?-1896	6.	4-42	- Oc	175 (100)) PANIE			
10a	USUAL OCCUPATION	N (Give kind of working life, even if retired	done 10b.	KIND OF BUSINESS O	R INDUST	RY 11 BIRTHPLACE (Stote	ar foreign country)	•	12 CITIZEI	N OF WHAT	COUNTR			
	Housewif	e				Littleto	n, N. C.		U.	S.A.				
13.	FATHER'S NAME					14. MOTHER'S MAIDEN I	NAME							
	Louis Ma	ввеу				Marie Mc	Lean							
15.		IN U. S. ARMED FOR		SOCIAL SECURITY NO	. 17, INF	DRMANT		Addr	·ess					
	No	, , , , , , , , , , , , , , , , , , , ,		None	Ce	celia McKoy	-Daughter	320	3 Pres	stman	St.			
	18. CAUSE OF DEAT	TH [Enter only one co	use per li	ine for (o), (b), and (c).]					INTERVAL E				
	PART I, DEAT	H WAS CAUSED BY:	Far	r advanced	bil	ateral pulm	onary the			ONSET AN	DEATH			
	00	IMMEDIATE CAUSE (d				<u> </u>	<u> </u>							
	Canditions, if on	0~/												
	gave rise to im	mediote												
	cause (a), stating the lying couse last.	he under- DUE TO	+											
z		P SIGNIFICANT CON		CONTRIBUTING TO DE	ATH BUT N	OT RELATED TO THE TERM	INAL DISEASE COND	TION GIV	EN IN PART 1	(a) 19 WAS	S ALTOPS			
CATO	120 11 0111	CA SIGNALICAN CON	0 110143	CONTRIBUTION TO DE	ATT BOT IS	OT RESIDED TO THE TERM	MAY DISEASE COMP	11014 014	CIA IIA I MV. II	PERF	ORMED?			
CERTIFICATION	200 ACCIDENT WAS OR CONTRIBUTING I (IF EITHER, NOTIFY A	CAUSE OF DEATH	20b DES	CRIBE HOW INJURY O	CCURRED	(Enter noture of injury in	Part I or Part II of ite	n 18 }						
3		Month, Day, Ye	or 20d. I	NJURY OCCURRED		E OF INJURY (Hame, fare			(Cou	inty)	(Stot			
MEDICA	Hour a.m p.m.	19	While of wor	Not while	rocn	ry, street, office bldg., et	C.)							
1		213-241-7-1			r .	Dec 13 10	57	. 6	10.67	41 . 211	4 2 1			
	21 I Certify that	(i) (inis nospito	i) anend	aea me deceasea	trom .	oth occurred al	Op.m.	, 04	" 1A O "	, mai (i)	(we) la			
	220. SIGNATURE	ed of ve on 94.	<u>-</u> .Z	19_0±, ond	thot de	oth occurred at	M, from the ca	uses on	d on the d	lote stote	226. DATE			
		9,	M.	Main lace	MIZ	D. PHYS. D	STAFF				SIGN			
	22c PHYSICIAN'S NAME (Type)	Edgars M.	Macı	ulans, M.	D.	Henryton	State Ho	sp.,	Henry	ton,	Md.			
230	BURIAL CREMATION	V. 236 DATE THERE)F	23c NAME OF CEM	ETERY OR	CREMATORY	23d LOCATION (Cit	y, town, c	or county)	(St	tote)			
K	EMOVAL (Specify)	7111:	.//	Massev	Cen	reterv	HARNAL	1.71	Co,	NO				
24	FUNERAL DIRECTOR'S	SIGNATURE A	1 19	ADDRESS		250 REC		25b. REGIS	STRAR'S SIGN	ATURE	7			
	Ritter	11110	1 20 70	9 12 612 xx	1/10	C T DATE U	L 1 2 '61	in	thun of the	2044				



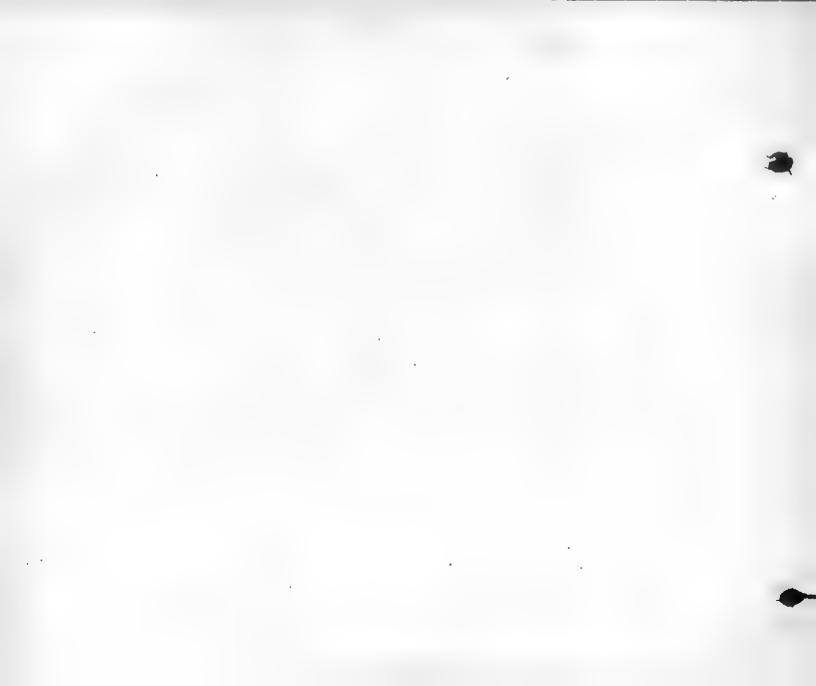
ARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH TH DEPT. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decassed lived, if institution; Residence before admission) ay is necessary, all director. Page for your files. Board of Health, a. COUNTY b. COUNTY Maryland Carroll MARYLAND b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (if outside corporata limits, write RURAL and give nearest town) write RURAL and give neerest town) Svkesville 3 mos. 3 days Baltimore #2 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street eddress) d. STREET ADDRESS Boar ON A FARM? retained be State B Springfield State Hospital 1324 Wirton St., Zone 2. YES NO TX 4. DATE 3. NAME OF Middle DECEASED DEATH (Type or print) William Harrison, Jr. 61 John July thin 24 hours and Give Pages 1, 2, and PM3. Page 5 may be ages 1 and 2 with 72 hours a 6. COLOR OR RACE 17. MARRIED X NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. 5. SEX last birthday | Months December 27, 1913 1.7 ya. Male White WIDOWED . DIVORCED 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? dona during most of working life, even if ratired) Marvland U.S.A. Machine Operator 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME John W. Harrison, Sr. Hilda Arnold 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) (If yes give war or detas of service) Springfield Hospital Records Office along with burial-transit perm 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral lobar pneumonia with multiple abscesses, Davs organism not determined. DUE TO Conditions, if any, which d "pending" i gave risa to immadiata cause DUF TO (a), stelling the undarlying PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a); 19, WAS AUTOPSY PERFORMED? Involutional depression (? 200 NO plnous 20b. DESCRIBE HOW INJURY OCCURED, (Entar nature of Injury in Part I or Part II of Item 18.) 2De. EXTERNAL CAUSE WAS PRIMARY | or CONTRIBUTING | ease execute the certificate, writing the should be forwarded to the Chief M FUNERAL DIRECTOR: Page 3 shi its designated agent; prior to burial. Month, Day, Year (County) 20c. TIME OF INJURY 2Dd. INJURY OCCURRED 2De. PLACE OF INJURY (Homa, farm, 20f. (City or town) (Steta) While Not While factory, street, office bldg., etc.) Hour' a.m. at work . at work . prior 21. I certify that I took charge of the remains described above, held an Autopsy 🔼 Inspection 🔼 Inquiry [30] and in my opinion Natural causes X Accident Suicide Homicide I Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER | DATE SIGNED SIGNATURE DEPUTY MEDICAL EXAMINER James T. Marsh, M.D. NAME (Type) Address (Street, c'ty, town, or county) 22a. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country) (State ā REMOVAL (Specify) Loudon Park Cemetery Baltimore 7-28-61 ₩40 p BURIAL 240. REC'D BY REGISTRAR 246. REGISTRAR'S SIGNATURE 23. FUNERAL DIRECTOR ADDRESS VS. A15ME Wm. Cook, Inc., 1217 St. Paul Street 5M 7/59 DATE



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH Reg. Dist. No. 7802 PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. COUNTY b. COUNTY MARYLAND funeral CITY OR TOWN (If outside corporale limits, write c. LENGTH OF STAY IN 16 OR TOWN (If outside corporate limits, write RURAL and give nearest town) RUKA. and give nearest/town) should Anchestor d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION STREET ADDRESS 15 RESIDENCE ON A FARM? by 12 YES T NO D NAME OF 4. DATE First Middle Month Day Year filler OF DEATH Pages (Type or print) 196 9 AGE (In years) 5. SEX OR RACE 8. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS MARRIED NEVER MARRIED lost birthday) Months Hours campiet DIVORCED [WIDOWED [7] paper USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? ngst of working life, even if retired) pup carban after . 13. FATHER'S NAME physician remave WAS DECEASED EVER IN U S. ARMED FORCES? 16 SOCIAL SECURITY NO. INFORMANT 716-10 attending 18. CAUSE OF DEATH [Enter only one couse per line jety[a], (b), and (c). INTERVAL PRIWEEN ā PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (o) **DUE TO** Conditions, if any, which gove rise to immediate **DUE TO** couse (o), stating the underlying couse last PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II af item 18) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f (City or town) (County) (State) foctory, street, office bldg., etc.) Haur a. m. While Nat while at wark the work 21. I certify that I attended the deceased from M 1922, that I last sow the deceosed that deoth occurred at 10 A alive on and _M, from the causes and on the date stoted above. FUNERAL DIRECTOR: ADDRESS (Street, city or town, state) ACTUAL SIGNATURE retained **PHYSICIAI** NAME (Type 220 BURIAL CREMATION, 22b. DATE THEREOF NAME OF CEMETERY LOCATION (City, towns or county) (Stote) abod Specify) 0 23. EUNERAL DIRECTOR'S SIGNATURE 24a. REC'D 8Y REGISTRAR 24b REGISTRAR'S SIGNATURE VS A15 (4) 2.5 '61 15M 9/58



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 CERTIFICATE OF DEATH 7803 Reg. Dist. No. U il director, filed with ofter death. Page 4 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased tived. If institut an: Residence before admission) a. COUNTY COUNTY MARYLAND the funeral should be fi b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give negres) lawn) RURAL and give neasest town) d NAME OF HOSPITAL Uthat in haspital, give street address) a. IS RESIDENCE OR INSTRUCTION ON A FARM? YES NO NAME OF Middle 4. DATE Year DECEASED OF July Ludwig Martin DEATH Pages (Type or print) Hilmert 19 61 Ē requires that the death certificate be executed within 5 SEX 6. COLOR OR RACE 7 MARRIED THEVER MARRIED B DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS last, birthday) Months Days Haurs DIVORCED T WIDOWED [carbon pape ofter death. 10a USJA, OCCUPATION (Give kind of work done 10b-KIND OF BUSINESS OF INDUSTRY (State or fareign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) aramount Engram pup Congranes 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 26. SOCIAL SECURITY NO. INFORMANT Address aftending | 1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)." INTERVAL BETWEEN ONSET AND DEATH ᇻ PART I. DEATH WAS CAUSED BY: Acute Coronary Thrombosis hour IMMEDIATE CAUSE (a) Generalized Arteriosclerosis Several year Canditions, if any, which gned gave rise to immediate **DUE TO** cause (a), stating the underlying cause last **burial-transit** PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) 19 WAS AUTOPSY removal, PERFORMEDA YES I NO P 20a. ACCIDENT WAS UNDERLYING [] 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20e. PLACE OF INJURY (Hame, form, 20f. (City or fown) 20d, INJURY OCCURRED (County) (State) factory, street, affice bldg., etc.) Haur a.m. While Nat while at work at work July 1961 that I last saw the deceased May 21. I certify that I attended the deceased from ___, and that death accurred at 7:25 M, from the causes and an the date stated above. may be Tretained by the O FUNERAL DIRECTOR: ADDRESS (Street, city or town, state) ACTUAL Main Street AL OR etained SIGNATURE PHYSICIAN'S W. B. Culwell Mount Airy, Maryland NAME (Type) 22a BURIAL CREMATION. 22b. DATE-THEREOF 22d LOCATION (City town, or county) 22c. NAME OF CEMETERY OR CREMATORY (State) ROMOVAL (Specify) FUNERAL DIRECTOR'S SIGNATURE ADDRES! 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE 141 2 6 '61 VII A15 (4) winning S. Traces 15M 9/58

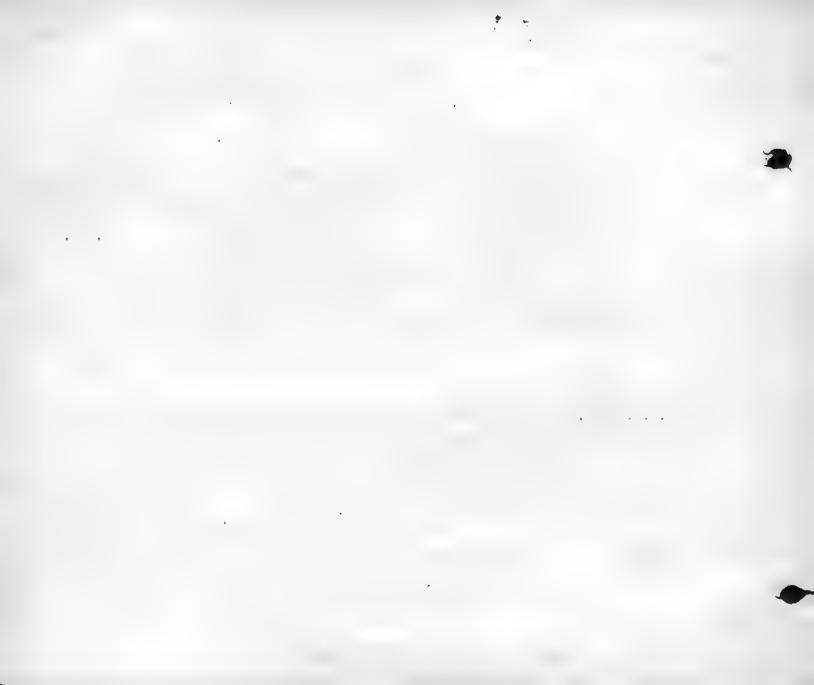


VR A15 (4) 15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 7804

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	PLACE OF DEATH a. COUNTY	Carroll	MARYLAND	2. USUAL RESIDENCE (WHO o. STATE Mary.	nere deceased lived If institution b. COUNTY	n. Residence before admission) Howard
		f outside corporate limits, write	c. LENGTH OF STAY IN 16	c CITY OR TOWN (If a	outside corporate limits, write RU	RAL and give nearest lown)
	Sykesvi	ile	lvr 4 mos 25	days Ellicot	tt City	15 2 4
_		AL (If not in hospital, give stree	N N	d STREET ADDRESS		e IS RESIDENCE ON A FARM?
7	Springf:	Leld State Hosp	ital	21 Cour	rt Ave.	YES NO ST
	3. NAME OF	First	Middle	Last	4. DATE Month	h Day Yeor
-	(Type or print)	Ka ti e I	ouise Richard	son Hobson	DEATH Ju	ly 6 1961
	S SEX	6 COLOR OR RACE 7. MAI	RRIED NEVER MARRIED	B DATE OF BIRTH	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	IF UNDER 1 YEAR IF UNDER 24 HRS
	Female	White widow	VED 🔼 DIVORCED 🗀	September 7	,1874 86 85k ys	Months Doys Hours Min
	100 USJAL OCCUPATIO	N (Give kind of work done 10b	KIND OF BUSINESS OR INDE	STRY 11. BIRTHPLACE (Stole	or fareign country)	12 CITIZEN OF WHAT COUNTRY?
-	Weaver	ing life, even if retired)		Marylan	đ	U.S.A.
	13 FATHER'S NAME			14. MOTHER'S MAIDEN N	NAME	
	Joshua Ri	ichardson		Kate Har	rrison	
4		R IN U. S. ARMED FORCES? 16	SOCIAL SECURITY NO. 17 I	NFORMANT	Addre	755
١	No	(If yes, give war or dates of service)	-	Springfield I	Hospital Record	ls
	18 CAUSE OF DEA	TH [Enter only one cause per	line for (a), (b), and (c).]			INTERVAL BETWEEN
	PART I, DEA	TH WAS CAUSED BY: IMMEDIATE CAUSE (0)	Bronchopneumon:	ia		davs
4	491	DUE TO		1000		
	Canditions, if a	ny, which) (b)				
	gave rise to in	mmediale (
	couse (a), stating lying cause lost.	(c)				
	G BAS II ASS		CONTRIBUTING TO DEATH BU	T NOT RELATED TO THE TERM	NAL DISEASE CONDITION GIVE	N IN PART I(a) 19 WAS AUTOPSY PERFORMED?
	N N N N N N N N N N N N N N N N N N N	200411211 00112120	, -14mm	water payoute.		YES NO
	C.B.S. as:	AS UNDERLYING [] 206 DE CAUSE OF DEATH MEDICAL EXAMINER)	SCRIBE HOW INJURY OCCURR	ED (Enter nature of injury in	Port I ar Part II af item IB }	
	3 20c TIME OF INJUR	Y Month, Day, Year 20d.	INJURY OCCURRED 200. P	LACE OF INJURY (Home, form	n, 20f (City or fown)	(County) (State)
	ZOC TIME OF INJUR	19 Whi	e Not while to	actory, street office b dg , etc	i.)	
			ided the deceased fram.	Feb. 31. 10	60 to 7-6-	
	saw the decease	F0 /	= 1067 1 Aba	death accurred at 2:3	O. D. III.	d an the date stated above
	220 SIGNATURE	sed drive dri	C / Ond High	deall accorded angles	Mi, Itom the cooses dire	22b DATE
	(Vinn	calmiclel 6	andro	M D PHYS D	ED STAFF PHYS	7-6-61
	ZEC PHYS CHANS		100	22d ADDRESS		
	NAMB/(Type)	Agustin delCar	npo, M.D.	Springfie	ld Hospital,Syk	cesville, Md.
	23a BJRIAL, CREMAT C		23c NAME OF CEMETERY	OR CREMATORY	23d LOCATION (City, town, o	r county) (State)
	REMOVAL (Specify)		Good Sheph		Ellicott Cit	
	24 FUMERAL DIRECTOR		ADDRESS			TRAR'S SIGNATURE
	The Carl	1.11	901.0011	A CATE JU	1 1 0 '61	



AND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH director, PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased fived If institution Residence before admission) a. COUNTY b. COUNTY MARYLAND Carroll . 77 7 77 uneral b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give negrest town! Moodba d. NAME OF HOSPITAL (If not in hospital, give street address) e IS RESIDENCE d STREET ADDRESS OR INSTITUTION ON A FARM? YES KI NO [Mor ja 1.01, cul 110 au Bossi NAME OF First. Middle 4. DATE Month Year DECEASED (Type or print) DEATH Jesuio Jamette 19. over S SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED IF UNDER 1 YEAR IF UNDER 24 HRS. B. DATE OF BIRTH 9. AGE (In years (ast birthday) Months Days Hours DIVORCED [WIDOWED | 10g USLAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working (ife, even if retired) "ousewife U.S.A. 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME John S. Sedicur Katherine Bowers 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17, INFORMANT Address Joseph Line 18. CAUSE OF DEATH [Enter only one cause peruline for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate DUE TO cause (a), stating the underlying cause lost, PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPS PERFORMED? YES NO D 20a. ACCIDENT WAS UNDERLYING A
OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part 1 or Part II of item 18) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20e PLACE OF INJURY (Home, farm, 20f (City or town) 20d, INJURY OCCURRED (County) (State) factory, street, office bldg., etc.) Hour a. m While Not while, at wark at work p. m. 21. I certify that (1) (this hasp tai) attended the deceased from , and that death accurred at 2. My 16th the causes and an the date stated above. saw the deceased alive on A 220 SIGNATURE ATTENDING M.D PHY5 DIRECTOR [22c PHYSICIAN'S 22d, ADDRESS NAME (Type) HOW r. 236 DATE THEREOF 23a BURIAL, CREMATION 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town, or county) (State) REMOVAL (Specify) Constant Howard County. 0 24. FUNERAL DIRECTOR'S SIGNATURE 25g REC'D BY REGISTRAR 256 REGISTRAR'S SIGNATURE Ciriling J. Throppe 15M 9/59

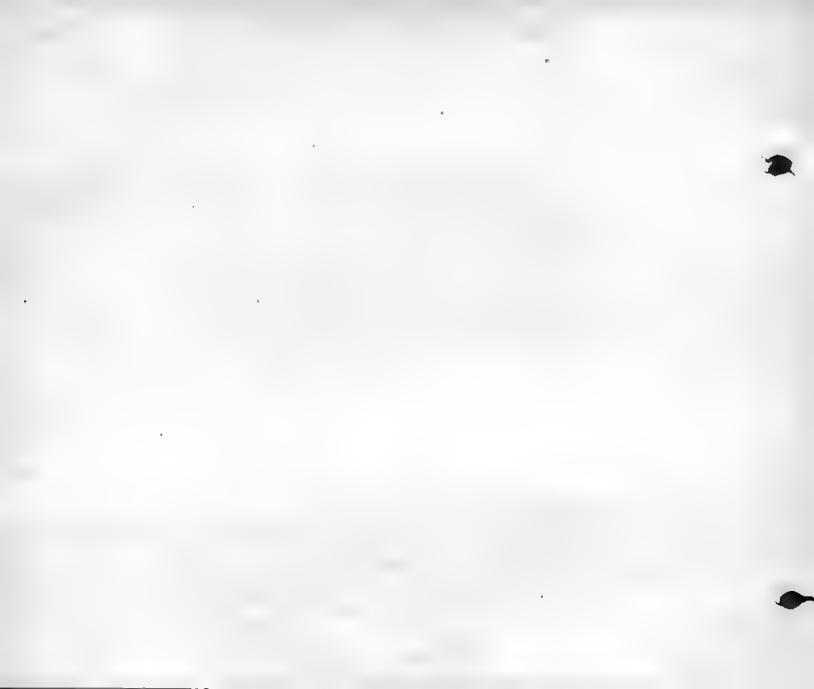


<u> </u>		DIVISION	OF STATISTICAL	L RESEARC	H AND RECORDS	, 301 W. PREST	ON STREET, I	- BALTIMORI	E 1, MARYI	AND
- m \			7806		CERTIFICAT	E OF DEAT	Н		f	7798
		Carrol City or town	lif outs de corporete lum	ts e.	MARYLAND LENGTH OF STAY IN 16	2. USUAL RESIDE o. STATE Mary. c. CITY OR TOWN		b. COUNTY Be	lto,	*
		Svkesv	d give neerest lown]	,	vr. 3 dvs.		gsville	The filling, with a sa		IS RESIDEN ON A FAR
×		Springs NAME OF DECEASED Type or print)	field State		Middle	Box	451 4. DATE OF DEATH	Month	Day	YES NO
	5.		6. COLOR OR RACE	ara	Elizabeth	Hurline DATE OF BIRTH		July AGE (In yeers IF	24 UNDER 1 YEAR	19 61
		Female	White	WIDOWED T		September 2			Aonths Deys	Hours Min
	10a	LSUAL OCCUPA	TION (Give kind of world	10b. KIND	OF BUSINESS OR INDUSTR	Y 11. BRTHPLACE (CO	ounty & State, or for		12 CITIZEN O	F WHAT COUNT
	do	H ousewij	orking life, even if ratire fa	(d)	_	Maryla	nd		17	S.A.
	13.	FATHER'S NAME			-	14. MOTHER'S MAID				• M. B. Cr. o
		Andrew	J. Meisner			Mary K.	Schmidt			
	15.	WAS DECEASED EV	VER NU.S. ARMED FOR	CES? 16. SOC	CIAL SECURITY NO. 17.		O CHILLEG C	Address		
	(10.	No. or unkown)	(If yesgive we rordetes of a	ervice)	5	Springfield	Hospital	Records		
	7		DEATH Enter only one	cause per line f	or (e), (b), end (c).)	brrugraora	ooproar	_	4 January I INT	ERVAL BETWEEN SET AND DEATH
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	MEDICAL CERTIFICAT	geve rise to immed (e), stelling the cause lest. PART I. OTHE CAUSE CONTRIBUTION (IN EXTENDED TO PART I. OTHER OF INDIFFE CONTRIBUTION (IN EXTENDED TO P. M.) 20c TIME OF INDIFFE CONTRIBUTION (IN EXTENDED TO P. M.) 21. I certify saw the decea	TION, 23b. DAJE THE	TIONS CONTRIB ith core 20b DESCRIB 20d. INJU Whi e et work tal) attended 7-24	Poral arteric E HOW INJURY OCCURED RY OCCURRED Not While et work the deceased from19.61., and that	ce of INJURY (Home, tory, street, office bidg.) death occured at ATTENDING PHYS. 22d. ADDRESS Springfice	orm. 201. (City of etc.), 1960, to 5:304, from DIRECTOR DATE TO THE COMPANY T	r town) 7-2/ The causes an	(County) , 19.61 the day	(Stete hat (1) (we) ate stated ab 22b. DA 7-24



MARYLAND STATE DEPARTMENT OF HEALTH 2807 CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Ca	rroll	MARYLAND		NCE (Where decease Maryland	ed fived of instituti b. COUNTY					
b. CITY OR TOWN (IF	outside corporate limits, writ	c. LENGTH OF STAY IN 15	E. CITY OR TO	WN (If outside corp	orote limits, write f	RURAL ond give	nearest lown)			
RuralSykes	ville	llm. lOdays	s Williamsport							
d. NAME OF HOSPITA	AL (If not in hospital, give stre	eet address)	d. STREET ADDRESS e. IS RESIDENC ON A FARM							
	State Hospita	1	30 W. I	Potomac S	treet		YES NO			
3. NAME OF DECEASED (Type or print)	Jane	Middle	Hutchinso	4. DATE OF DEATH	Moi 7		Doy Year 31 1961			
S SEX	6 COLOR OR RACE 7 MA	ARRIED NEVER MARRIED	8. DATE OF BIRTH		9. AGE (In years		AR IF UNDER 24 HR			
female	white wood	OWED DIVORCED	10/28/79		lost birthdoy) 81 yrs	Months Doy	s Hours Min.			
10a. USUAL OCCUPATIO during most of worki General wo	ng life, even if retired)	66. KIND OF BUSINESS OR INC UNEXCO	/		country)	12 CITIZEN	OF WHAT COUNTR			
13. FATHER'S NAME		4	14. MOTHER'S MA	AIDEN NAME						
John Morri	.8		Elizab	eth McDo	nald					
	IN U.S. ARMED FORCES? f yes, give war or dates of service)		informant pringfield	Hosp. re		Sykes	ville, Md			
E CBS associ	mediate DUE TO er SIGNIFICANT CONDITION ated with sen	HS CONTRIBUTING TO DEATH B AILE brain dise DESCRIBE HOW INJURY OCCUR	ase with ps	ychotic :	reaction.		19 WAS AUTOPS PERFORMED? YES TO NO			
	MEDICAL EXAMINER)									
YOU TIME OF INJURY HOUR O. M.	, Wh		PLACE OF INJURY (Hot foctory, street, office b	ldg., etc.)	ly or town)	(Coun	ty) (Sto			
saw the decease	7/21	ended the deceased from	8/19 t death accurred o	1960 .ta	7/31 the causes a					
22c PHYSICIAN'S	i fi Ma	retur ME	M D ATTENDING PHYS 22d. ADDRESS	MED DIRECTOR		- TI	7/31/6			
NAME (Type)		olin, M.B.			ield Stat lle, Mary	-				
230 BURIAL, CREMATION AMOVAL*(Specify)	8-3-6/	23c NAME OF CEMETERY	OR CREMATORY	23/2/00	ATION (City, lown,	new, 7	your			
24 FUNERAL DIRECTOR'S	SIGNATURE	Sykloville	can	SO. REC'D BY REGI		ISTRAR'S SIGNA				



Division of STATESUCAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE I, MARYLAND **EXAMINER'S CERTIFICATE OF DEATH** TH DEPT 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before edm ssion) y is necessary, I director, Page or your files. a. COUNTY b. COUNTY a. STATE Carroll. Maryland Balto City MARYLAND b. CITY OR TOWN (if outside corporate lim ts, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 for your foard of write RURAL and give neerest town)
Sykesville Lmos 23days Baltimore 13 d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) a. IS RESIDENCE ON A FARM? 3554 Lyndale Ave. Springfield State Hospital YES NO X 3. NAME OF Middle 4. DATE Month Edward Olai July 28, 19 61 (Type or print) Johannesen DEATH with 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5 SEX 8. DATE OF BIRTH 9. AGE (In years , IF UNDER 1 YEAR) IF UNDER 24 HRS. may 12 wij last birthday) Months i Devs December 4, 1893 White Male WIDOWED -DIVORCED | . Give Pages 1, 2, as om PM3. Page 5 r. File pages 1 and 2 vent ment mithin 72 how 10a. USUAL OCCUPATION (G ve kind of work 1 1Db. KIND OF BUSINESS OR INDUSTRY | 11. B RTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? dona during most of working life, aven if retired) U.S.A. Rigger (Bethlehem Steel Company) Norway 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Marie Monsal Johannas O. Olson 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) (Ifyasgivewarordetasofservica) along with I Springfield Hospital Records No 18. CAUSE OF DEATH [Enter only one cause par line for (a), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH PART J. DEATH WAS CAUSED BY: " in pencil i Office alor burial-trans Terminal pulmonary thrombosis and infarction. days IMMEDIATE CAUSE (a) DUE TO Arteriosclerotic cardio-vascular disease. Conditions, if any, which vears gave rise to immediate cause DUE TO (a), stating the underlying General arteriosclerosis - serero. cause last. C.B.S. assoc. with cerebral arteriosclerosis. YES X NO -CERTIFICA plnods 20a, EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of injury in Part I or Part II of item IB.) PRIMARY | or CONTRIBUTING | should be forwarded to the Chief Me FUNERAL DIRECTOR. Page 3 sho CAUSE OF DEATH. 20c. TIME OF INJURY 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, Month, Day, Yaer 20f. (City or lown) (County) (State) factory, street, office bldg., etc.) While Not While Hour a.m. et work - at work prior 21. I certify that I took charge of the remains described above, held an Autopsy 🗍 . Inspection 🔀 Inquiry A and in my opinion death resulted from: Natural causes Accident 7 Suicide Homicide Undetermined menner CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER DATE SIGNED SIGNATURE DEPUTY MEDICAL EXAMINER IX EXAMINER'S 7/28/61 James T. Marsh, M.D. NAME (Type) Address (Streat, city, town, or county) 220. BURIAL, CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country) (State) REMOVAL (Specify) /61 Paul's Cemetery Baltimore, Md. **₽40** ▮ Burial 24a, REC'D BY REGISTRAR I 24b, REGISTRAR'S SIGNATURE E.Schimunek Funeral Home VS. A15ME arthur & Health 5M 7/59 Brehms Lane

RYLAND STATE DEPARTMENT OF HEALTH



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- } '	A. COUNTY					2.	USUAL RESIL			vad, If in: . COUNT	и		re admiss?
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I				f not in hosp	itel, give street eddrei	(4)	d. STREET ADDI						RESIDEN
Ш	G	amber	Road				/ Gambe	r Road				YES	□ мо [
3	NAME OF		First		Middie		Lest	4. DAT	Е	Month		Day	feer
	(Type or pri		Bertha		Emaline	Kee	eney	DEA	TH ,	July	31,		1961
H 7	. SEX	6.	COLOR OF RACE	7. MARRIED	NEVER MARRIED	DI B, DA	TE OF BIRTH		9. AGE (I	n years li	FUNDER 1 Y		
	Female		hite	WIDOWED			Oct.27,1	.883	last bir	yrs.	Months De	ys Hour	s Min
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Г		Housew	g life, even if retira	d)			Maryla	nd			1	U.S.	
V	3. FATHER'S					1 14.	MOTHER'S MAI	DEN NAME					-
Г)	James	E.Morris	3			Emma K	ing					
1	5. WAS DECE		N U.S. ARMED FOR		OCIAL SECURITY NO). 17. INFO	RMANT			Address			
1			give wer or detes of s	ervice)	Vone	1	Mary Mai	sel.E11	icott	City	r.Md.		
-		E OF DEA	TH (Enter only one		ne for (e), (b), end (c)		, , , , , , , , , , , , , , , , , , , ,	,			,	INTERVAL	BETWEEN
					ral Hemorr		ith Left	side H	emipl	egia		ONSET AI	4D DEATH
	1	IMN >	SEDIATE CAUSE (e)	Hunor	tensive	nage w	Ten Dere	. 5200		-0		1 4 0	d.e
		No. of the last			ioscleroti	c C-V	Dicosco					6 y	rs.
		fany, w Immediele	107	ALLEI	TOSCIETOCI	C 0-4	DISCASE						
	(a), slolin	The under											
1.	cause last.		<u> </u>		FRIBUTING TO DEATH	I BLIT LOV BEI				-	1 1 7 4 7 7 1		C 41 701
MOUTA TIME	PARI	. OTHER SIG	SNIFICANT CONUI	IIONS CON	KIBUTING TO DEATH	BUI NOT KE	LATED TO THE TI	KWINAL DISEA	SE COMPILI	ON GIVER	N N FAKI I	PE	RFORMED
13	5											YES	NO 2
PTTG	OR CONTR	BUTING []	UNDERLYING [] CAUSE OF DEATH	20b. DESC	RIBE HOW INJURY O	CCURED. (Ent	er nature of injur	y in Pert I or Pe	rt II of item	18.)			
			THO LE AMINER	no									Salar whee
IAPINSTA	20c. TIME	OF INJURY	Month, Day, Ye	\$475.tf.	NJURY OCCURRED :				City or lown	}	(Count	λ)	(State)
1 9							arest, office bldg						
1 1		p.m. I	none 19	el work	al work mon	e	treet, office bldg	.,	none				
	21. I ce	p.m. I	(I) (Ibisc kossei	attend	led the deceased	from 3-	21-41	, 19,	lo 7-3		, 19		
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-2	21. I ce saw the 22a. SIGN 22c. PHYS NAW 3a. BURIAL, REMOVAL BURIAL	p.m. I deceased ATURE CIAN'S E (Type) D. CREMATION. (Specify) al	(I) (Ibix ROSPO alive on	es, M.	D	from. 3- nd that dea	21-41 Attending Phys. 22d. Address 6 Hanov Rematory	MED. DIRECTOR MED. DIRECTOR PET Rd. 233d. to Fi REC'D BY REC All G 4	om the complete state of the complete state	terst	town,	8-1 Md.	ated about 22b. DAT -6 1

MARYLAND STATE DEPARTMENT OF HEALTH



STATISTICAL RESEARCH AND RECORDS --- BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 07802 director, With 1. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased level If institution: Residence before admission) DUNTY filed. ь социту MARYLAND the funeral should be fi b. CITY OR TOWN (If autside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN corporate limits, write RURAL and give nearest town RURAL and give nearest town) d. STREET ADDRESS NAME OF HOSPITAL (If not in OR INSTITUTION e. IS RESIDENCE ON A FARM? haspital, give street address) YES TI NO Z 3. NAME OF 4. DATE First Middle Last Month Day Year **DECE ASED** OF DEATH (Type or print) 196 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS S SEX 6 COLOR OR RACE MARRIED NEVER MARRIED last birthday) Manths Days Hours DIVORCED [WIDOWED Z USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 11, BUTHPLACE 12 CITIZEN OF WHAT COUNTRY? ring most of working life, even if retired) pup 13. FATHER'S NAME 14. MOTHER SJAAIDEN NAM U. S ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT attending p INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I, DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO been signed by I-transit permit. Canditions, if any, which gave rise to immediate **DUE TO** cause (a), stating the underlying cause last phys.cian. Б PART H. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED: YES TI NO 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month. Day. Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f (City or town) (County) (State) factory, street, affice bldg , etc.) Haur a m. While Nat while p. m. at wark at wark 21 I certify that (I) (this haspital) attended the deceased fram that (I) (we) last , and that death accurred at 9 5 M, from the causes and an the date stated above TO FUNERAL DIRECTOR: A nage 3 shauld be detach 1961 sow the eleceased alive an 22o, SIGNATURE ATTENDING M.D DIRECTOR . Board 226 PHYSICIAN 22d. ADDRES page 3 the State BUR AL, CREMATION 236 DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCALION (City, fawn, or county) DINERAL DIRECTOR'S SIGNATURE ADDRES! 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 15M 9759



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institutions Residence before admission) 1. PLACE OF DEATH e. COUNTY b. COUNTY Carroll Marvland Balto, City MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outs de corporate limits, write RURAL and give neerest town) write RURAL and give nearest town) Limos.5days Baltimore 5 Svkesville d. STREET ADDRESS m. IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ON A FARM? YES NO 2020 McElderry Street Springfield State Hospital NAME OF Middle DECEASED John Robert Klumpp July (Type or print) DEATH AGE [In years | IF UNDER 1 YEAR | IF JNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED ANEVER MARRIED 8. DATE OF BIRTH last birthdey) Months, Devs October 29,1888 Male DIVORCED [WIDOWED [12. CITIZEN OF WHAT COUNTRY? 10b. KIND OF BUS NESS OR INDUSTRY | 11 BIRTHPLACE (County & State, or fore gn country) 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S.A. Maryland Truck Driver 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Nicholas Klumop Ida Stout 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) | (If yes give wer or detes of service) Springfield Hospital Records INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c). ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Acute renal insufficiency Days IMMEDIATE CAUSE (a) Sepsis Davs Conditions, if any, which (b) geve rise to immediate cause DUE TO (e), steting the underlying C.B.S. association conditions contributing to death but not setated to the terminal disease condition given in part 1(a) 19. Was autopsy C.B.S. association cerebral arteriosclerosis. Hypertensive arteriosclerotic performent cardiovascular disease. Diabetes Mellitus. 200. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert I or Pert I of tem 18.) MEDICAL 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form,) (County) (Stete) 20f. (City or town) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Not While While Hour #.m. et work et work 21. 1 certify that (I) (this hospital) attended the deceased from March 20, ..., 19.61, to July 25,, 1961, that (I) (we) last saw the deceased alive on July 25, 19.61, and that death occured at 10.285 PMm the causes and on the date stated above. 220. SIGNATURE **ATTENDING** DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S Springfield Hospital, Sykesville, Md. Julian Radcykowycz, M.D. (State) 23d. LOCATION (City, town or county) 230, BURIAL, CREMATION, 236. DATE THEREOF Baltimore National Frederick Rd. 25a, REC'D BY REGISTRAR 25b, REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) arthur S. Kraus Schimunek Funeral Home Inc. 15M 9/60 2601 E. Madison Street

MARYLAND STATE DEPARTMENT OF HEALTH



07804 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission o. COUNTY filed COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write LENGTH OF STAY IN 16 corporate limits, write RURAL and give nearest town RURAL and give nagrest town) d. STREET ADDRESS e. IS RESIDENCE ON A FARMS YES NO NAME OF 4. DATE Mont Year DECEASED (Type or print) DEATH 6. COLORIOR RACE 7. MARRIED UNDER 1 YEAR! IF UNDER 24 H NEVER MARRIED last birthday) Months Doys DIVORCED [WIDOWED IV 12. CITIZEN OF WHAT COUNTRY? 10a. USUÁL OCCUPATION (Give kind af work done) 10b. KIND OF BUSINESS OR INDUSTRY during most of working life, even if retired 14 MOTHER S MAIDEN NAME ARMED FORCES? SOCIAL SECURITY NO. 17 INFORMANT 18. CAUSE OF DEATH [Enter only one course per line for (a), (b), and (c)] ONSET AND DEATH PART I. DEATH WAS CAUSED BY-IMMEDIATE CAUSE (a) Droncho DUE TO A.S. C. W disease Conditions, if ony, which gave rise to immediate **DUE TO** couse (a), stating the underlying couse lost. PART II. OTHER SIGNIFICAND CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? YES NO T 20g. ACC DENT WAS INDERLYING [] 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item IB.)
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MARYLAND STATE DEPARTMENT OF HEALTH



DIVISION OF STATISTICAL RESEARCH AND RECORDS - BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) PLACE OF DEATH a. COUNTY Baltimore filed Maryland Carroll' MARYLAND b. CITY OR TOWN (if outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville 3Mos - 2Lidas Baltimore 14. M e IS RESIDENCE d, NAME OF HOSPITAL (If not in haspital, give street address)
OR INSTITUTION ON A FARM? 3004 Woodside Ave YES NO Springfield State Hospital NAME OF 4. DATE Middle Month Year DECEASED (Type or print) DEATH July death. 19 6 Charles Albert. Magee B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED lost birthdoy) ofter o Hours WIDOWED [DIVORCED | Male papers 12. CITIZEN OF WHAT COUNTRY? 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (State or foreign country) hours during most of working life, even if retired)
Machinist Pennsylvania U.S.A. 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME David Francis Magee Lewrainer G. Twaddell 17 INFORMANT IS, WAS DECEASED EVER IN U. S. ARMED FORCES? 16, SOCIAL SECURITY NO. Address (Yes, no, or unknown) Springfield State Hospital Records 1B. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c)." INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (o) Bacteremia **DUE TO** 10 1111 Conditions, if ony, which Supparative Nephritis gove rise to immediate per **DUE TO** couse (o), stoting the underlying cause lost PART 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES RI NO I 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c TIME OF INJURY Month. Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) foctory, street, office bldg., etc. Hour o.m. While Not while of work of work p. m. March 21 I certify that (1) (this haspital) attended the deceased fram. ond that death accurred at _____PM, from the causes and an the date stated above saw the deceased alive an 22º SIGNATUR SIGNED ATTENDING STAFF DIRECTOR [] PHYS 22c PH/S CIAN NAME (Ty) FUNERAL 23g SURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATOR' 23d LOCATION (City, town, or county) page the Sto REMOXAL (Specify) 0 256, REGISTRAR'S SIGNATURE ADDRESS: 250. REC'D BY REGISTRAR '61 Corthur & Kinus 15M 9/59



MARYLAND STATE DEPARTMENT OF HEALTH

Page

after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **CERTIFICATE OF DEATH** Reg. Dist. No. ofter death. Page 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) · COUNTY Carroll Co. b. COUNTY MARYLAND Maryland Carroll b. CITY OR TOWN (If autside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Rural Rd#4 Westminster, Md. Rural Westminster. Md. yrs. d. NAME OF HOSPITAL (If not in haspital, give street address) d STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? Baltimore Blvd. YES NO NAME OF 4. DATE Middle Manth Year 15 Effie Susan Dean MaComas DEATH July 196I (Type or print) 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED **B DATE OF BIRTH** right birthday) Peb. 29, I884 Manths WIDOWED I DIVORCED | 10a. USUA. OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) U.S.A. Maryland and carba 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME physician Richard Owings Francis E. Shipley 15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO INFORMANT Address 220-05-958ID Lewis W. McComas Sr. Rd#4 Weatminster. Md. 1B. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c)] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (Q) DUE TO Canditians, if any, which gave rise to immediate DUE TO cause (a), stating the underlying cause last PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPS PERFORMED? YES NO Z 20a ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part III of Item 1B.) OR CONTRIBUTING IT CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY 20e PLACE OF INJURY (Home, form, 20d INJURY OCCURRED 20f. (City or town) Day, Year (State) factory, street, office bidg. etc.) Haur a m. While Not while at work at work 21. I certify that I attended the deceased from 1622/_,that I last saw the deceased c, and that death accurred at OP alive an M. fram the causes and an the date stated above. ADDRESS (Street, city or town, stote) Main St. Reisterstown. ACTUAL SIGNATURE PHYSICIAN'S Dr. James G. Saffell /Sr. NAME (Type) 220 BURIAL CREMATION, 225. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State) Deer Park Methodest Cem. Reisterstown, Md. 0 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Cirthur & Kraus 15M 9/SB

form . The shall .

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND 07809 CERTIFICATE OF DEATH I directar, filed with PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased ived If institution Residence before admission) o. COUNTY b. COUNTY MARYLAND drrol b CITY OR TOWN (If outside corporate limits, write c LENGTH OF STAY IN 16 c. CHY OR TOWN of outside corporate limits, write RURAL and give nearest town) RURAZ and give nearest town] b.STFH d. NAME OF FOSP TAL (If not in hospital, give street address) d STREET APDRESS IS RESIDENCE YES NO 4. DATE OF DEATH NAME OF Middle DECEASED (Type or print) AGE (n years lost birthday) IF UNDER 1 YEAR IF UNDER 24 HRS SEX 7. MARRIED NEVER MARRIED Months Days Hours DIVORCED | WIDOWED OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 12 CITIZEN OF WHAT COUNTRY? fost of working life, even if retired) 17 INFORMANT EVER IN U.S. ARMED FORCES? Address 216-01-80401 INVERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one couse per line [ar [a], b), and (c).] ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) **DUE TO** Canditions, if any, which (b) gove rise to immediate DUE TO couse (o), stating the underlying couse lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0, 119 WAS AUTOPS) PERFORMED? OR CONTRIBUTING CLEAUSE OF DEATH 20b DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part It of item 18) (IF EITHER, NOTIFY MED CAL EXAMINER) 20c. TIME OF INJURY Month, 20e PLACE OF INJURY (Home, form, 20f (City or town) Doy Year 20d INJURY OCCURRED (County) (Stote) foctory, street, office bldg, etc. Hour om While Not while of work at work p. m 21 I certify that (1) (this hospital) attended the deceased from 2 19.0 €, that (I) (we) last . and that death occurred at . M. from the causes and an the date stated above saw the decealed alive on 220 SIGNATURE M.D PHYS MED DIRECTOR PHYS 22c PHYS CIAN S NAME (Type) 23a BURIAL, CREMATION, 23Ь NAME OF CEMETERY OR CREMATORY 23d Stote) 0 25b REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR S.SIGNATURE 250 REC'D BY REGISTRAR AUG DATE C. 11 was 9 55 1SM 9/59



DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 7818 With I directar, filed with PLACE OF DEATH 2, USUAL RESIDENCE (Where deceased lived If institution; Residence before admission o. COUNTY a. STATE b. COUNTY MARYLAND Carrol. Marvland Carrol] funeral o b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give negres! town) Tanevtown Rural Tanevtown Rural d NAME OF HOSPITAL (If not in hospital, give street address) STREET ADDRESS e IS RESIDENCE OR INSTITUTION ON A FARM? 24 YES NO -R.F.D R.F.D NAME OF 4. DATE First Middle lost Month Day Year DECEASED OF (Type or print) DEATH Savilla. Ohler 19 6] July IF UNDER 1 YEAR IF UNDER 24 HRS 5 SEX 6. COLOR OR RACE 7. MARRIED 🕢 NEVER MARRIED 🔲 B. DATE OF BIRTH 9. AGE (In years lost birthdoy) Months Days WIDOWED [DIVORCED [] Female a 100 JSUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY | 1) BIRTHPLACE (Stoke or foreign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) and U.S.A Housework Own home Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME John H. Cluts Hettie 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT Address D Raymond Ohler Tanevtown Maryland No attending 1B. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH ă PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o DUE TO ģ permit. Conditions, if ony, which gned gove rise to immediate DUE TO couse (o), stoting the underlying couse lost burial-transit peen b PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO WAS AUTOPSY emation, PERFORME D? has YES NO T 20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part (I of item 18.) certificate (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Doy, Year Month. 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) foctory, street, office bldg., etc.) Hour a.m. While Not while at work of work p. m 21 1 certify that (I) (this bospital) attended the deceased from 1927£, thot (I) (₩e) last Pa Health detach saw the deceased olive on ond that death occurred at 2 A.M. fram the causes and on the date stated above. DIRECTOR: 220 SIGNATURE 226 DATE SIGNED ATTENDING PHYS. M.D. DIRECTOR 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type FUNERAL 23a BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town, or county) (Stote) REMOVAL (Specify) Lutheran Cemeterv Tanevtown. Maryland 0 24. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 25g, REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE DATE UL 2 7 '61 Chilling L. Thomas .Fuss & Son Taneytown, Maryland

death.

death

LAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS -- BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) p COUNTY **P CORNTY** Maryland Balto. City MARYLAND Carroll b CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville Baltimore 24 11 days IS RESIDENCE d NAME OF HOSPITAL (If not in hospital, give street address) d STREET ADDRESS Springfield State Hospital 323 S. Bouldin Street YES INO TE NAME OF Middle DECEASED John Joseph Ovelgone DEATH July 10. 1967 (Type or print) 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS 9. AGE (In years lost birthday) Male White December 2, 1906 WIDOWED | DIVORCED | 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? Trucking - Penna Reilroad U.S.A. Marvland 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Henry Ovelgone Mary Siber 17. INFORMANT 15 WAS DECEASED EVER IN L. S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address NO Unknown Springfield Hospital Records 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) Bronchooneumonia Davs DUE TO Conditions, if ony, which gove rise to immediate DUE TO couse (o), stoting the under-

lying couse lost. S. 2550C. WITH CISCASES OF UNCERTAIN OF UNKNOWN CAUSE (HUNTLINGTON S PERFORMED? YES NO 2 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Part II of I tem 18.

20c TIME OF INJURY 20e PLACE OF INJURY (Home, form, 20f (City or town) Doy, Year 20d. INJURY OCCURRED (County) foctory, street, office bldg., etc.) Hour o.m. Not while While of work of work

21 I certify that (1) (this haspital) attended the deceased from June 29, 1961, ta July 10, 1961, that (1) (we) last saw the deceased alive an July 10, 1961, and that death accurred a 2 20 Mrom the causes and an the date stated above 220 SIGNATURE

(Stote)

(Stote)

ATTENDING MED DIRECTOR 22d. ADDRESS

Agustin delCampo, 4.D. Springfield Hospital, Sykesville, Md. 230 BURIAL, CREMATION, 236 DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City, fown, or county)

REMOVAL (Specify) Oak Lawn Cemetery Colgate, Maryland burial 24 FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 25g REC'D BY REG STRAR 2Sh REGISTRAR'S SIGNATURE Circling & Kraus

Ullrich Funeral Home, Dundalk, Maryland

p. m.

DATEJUL 1 2 '61



VR A15 (4) TSM 9/S9

MARYLAND STATE DEPARTMENT OF HEALTH

7820 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

07812

1. PLACE OF DEATH O. COUNTY Carroll MARYLAND					2 USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) o. STATE b. COUNTY Balto. City							
b. CITY OR TOWN (If outside corporate limits, write			c. LENGTH OF STAY IN 16	C.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lown))		
	RURAL and give nearest town) Sykesville			days	Bal	timo	re		>V	5 1 1	+	
d. NAME OF HOSPIT	AL (If not in haspital, g	ive street	address)		. STREET ADDRESS					e, IS RES	IDENCE FARM?	
	field State	e Hos	pital		708 Dr	ryden	Drive				NO 🚾	
3. NAME OF DECEASED	Fix		Middle		Last	4. DA	TE	Mont	h	Day	Year	
(Type or print)	Raymond		Archie		Phebus DEAT		ATH	H July		13,	19 61	
S. SEX		7 MARE	MARRIED MEVER MARRIED E		TE OF BIRTH 9 AGE (In			(In years	yeors IF UNDER 1	YEAR IF UNDE		
Male	White	WIDOWI			ne 3, 189	75	100	ovrtladay) OO yrs	Months [Days Hours Min.		
10a USUAL OCCUPATIO	ON (Give kind of work-	dane 10b	KIND OF BUSINESS OR IND	USTRY	11. BIRTHPLACE (Sto	te ar forei	gn country)			EN OF WHAT C	OUNTRY?	
Banking	ang me, even a remed	'	-		Maryland				Ĭ	U.S.A.		
13. FATHER'S NAME				14.	MOTHER'S MAIDEN	NAME						
Eugene Ph	ebus.				Florence	e Mil	Ller					
15 WAS DECEASED EVE	R IN U.S. ARMED FOR	CES? 16.	SOCIAL SECURITY NO. 17	INFORM	IANT			Addr	ess			
(Yas, no. or unknown)	(iii yes, give war or outes or i	-	216-03-8008		Springfi	eld F	lospit	al Re	cords			
18. CAUSE OF DEA	ATH (Enter only one co	use per li	ne for (o), (b), and (c).}							INTERVAL BE	TWEEN	
PART I DEA	TH WAS CAUSED BY.	R	heumatic hear	t di	sease					Years	DEATH	
hot 1.	DUE TO	/										
Conditions, if o	ny, which) (b	1										
gave rise to i	mmediate (DUE TO											
lying couse last.	Ina Under-	1										
Presentl	Part II. OTHER SIGNIF CAN'T CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19 WAS AUTOPSY PERFORMED? PERFORMED? YES X NO											
200 ACCIDENT WORK CONTRIBUTING	AS UNDERLYING AS CAUSE OF DEATH MEDICAL EXAMINER)	20b. DES	CRIBE HOW INJURY OCCUR	RED. (Ent	er noture of injury	in Port I a	Part II of il	em 1B)				
Hour a.m.	Y Month, Day, Ye	or 20d. I While at wor	Not while f		F INJURY (Home, fo streel, office bldg.,		(City or tow	n)	(Co	ounty)	(Stote)	
21. I certify the) attend	ded the deceased fram	Mar	ch 7,					L, that (I) (
22a SIGNATURE		f.	o /	dediti	discorred di		arr rile co	30303 011	o on me	22	b DATE	
Can	alin de	el 6	pourte	M D	ATTENDING PHYS	MED. DIRECTOR	STAF	5. [X		7/	13761	
22 PHYSIC AN'S					22d. ADDRESS							
NAME (Type)	Agustin de	LCamp	o, M.D.		Springfi	eld F	lospit	al,Sy	kesvil	lle Mar	vland	
23a BURIAL, CREMATIC)F	23c NAME OF CEMETERY	OR CRE			DCATION (C					
REMOVAL (Specify Burial	7/17/6:	L	Druid Ridg	e C	emetery		altimo					
24 FUNESAL DIFFCEPE			00 Miserty He			EC'D BY RE	GISTRAR	2Sb REGIS	TRAR'S S G	NATURE		
Cusu	orda le	mal	not .		DATE	111	7-61-		-1-0-	<i>y</i>		



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS - BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 7827 director Poge PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. COUNTY filed b. COUNTY MARYLAND after death. the funeral c should be fil b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate filmits, write RURAL and give nearest lown) RUBAL and give nearest lown) teller WLECK d. NAME OF HOSPITAN d STREET ADDRESS e. 15 RESIDENCE OR INSTITUTION ON A FARM? 24 YES NO IP NAME OF Middle DECEASED DEATH (Type or print) 9. AGE (In years last birthday) S SEX 6 COLOR OF RACE IF UNDER TYEAR IF LINDER 24 HRS MARRIED TW NEVER MARRIED Months ofler WIDOWED IT DIVORCED [10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY during most of working I fe, even if retired) 14 MOTHER'S MAIDEN NAME 15 WAS DECEASED EVER IN U. 5 ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT Address 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 18 mg Carcinomatosis **DUE TO** Conditions, if any, which Carcinoma of Lung Unknown gave rise to immediate **DUE TO** cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(g) 19 WAS AUTOPSY PERFORMED? YES NO 🗔 200. ACCIDENT WAS UNDERLYING A CONTRIBUTING CAUSE OF DEATH 20b DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY 20e PLACE OF INJURY (Home, form, 20f (City or town) Day, Year 20d. INJURY OCCURRED (County) (State) factory, street, office bldg., etc.) use d b Haur o. m. While Nat while at work at wark p. m. prior 21. I certify that (I) (this haspital) attended the deceased fram In. warry ... 1960 , to Iuly 25 ..., 19.61, that (I) (we) last pached July 24-19 61, and that death accurred at 15 Mafram the causes and an the date stated above saw the deceased alive an. DIRECTOR: 22a_SIGNATURE 22b, DATE SIGNED PHYS M D DIRECTOR 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) Hampstead, Maryland M.C. Porterfiel FUNERAL 23b. DATE THEREOF 230 BURIAL CREMATION. 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City, town, or county) REMOVAL (Specify) 0 25a. REC'D BY REGISTRAR FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 256 REGISTRAR'S SIGNATURE DATE JUL 2 8 '61 VR A1S [4] arthur & Kraus 1SM 9/59



	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMOR CERTIFICATE OF DEATH	07814
M	1. PLACE OF DEATH e. COUNTY 2. USUAL RESIDENCE (Where decessed lived, if interpretation of the country of the	Υ /
	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest fown) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write if outside corporate limits is outside corporate limits.	Carroll RURAL end give neerest town)
15	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS The street address of the street ad	a. IS RESIDENCE ON A FARM
**************************************	3. NAME OF DECEASED First Middle Last A. DATE Month	Day Yaar
		= 22 1967 FUNDER 1 YEAR IF UNDER 24 HRS
	female white widowed T Divorced 9/1/63 77 yrs.	Months Days Hours Min. 12. CITIZEN OF WHAT COUNTR
	done during most of working life, even if ratified	U.S.A.
I	Thomas Edmondson 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT Address	
	(Yes, no, or unkown) (Hyesgivawarordalesofservice) 18. CRUSE OF DEATH [Enter on y one cause per line for (a), (b), end (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lotive pulmohary TB - advanced.	INTERVAL BETWEEN ONSET AND DEATH
	Conditions, if any, which gave rise to immediate causa (e), steting the underlying causa lest. DUE TO DUE TO (b) DUE TO (c)	
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVE CONTRIBUTION OF CONTRIBUTIO	PERFORMED?
	2De. Time OF INJURY Month, Day, Year 20d INJURY OCCURRED 2De. PLACE OF INJURY (Home, ferm, Hour e.m., While Not While at work at work at work	(County) (State)
	21. I certify that (I) (this hospital) attended the deceased from 9/28/60, 19, to 7/22/61	
	226. SIGNATURE COLLY CATELY AD. ATTENDING MED DIRECTOR PHYS. TO DIRECTOR PHYS. TO DIRECTOR PHYS. TO DIRECTOR PHYS. TO DIRECTOR TO PHYS.	22b. DATE SIGNI
1	NAME (Type) Julian Cadzykanycz, 1.13. Springfield Hospital, 3 230. Burial, CREMATION, 133b. DAYE THEREOF, 123c. NAME OF CEMETERY OR CREMATORY (23d. LOCATION (City, low)	
()	Barral 7/24/6/ Prox a Cemetry Gambe	STRAN'S SIGNATURE
	J. E. Mujero, Ja frest prom 26 mobate SUL 25'61 a	thur S. Krons



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY **b.** COUNTY by the and 2 death. Carroll MARYLAND Balto. City Maryland b. CITY OR TOWN (if outs de corporata limits, E LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate timits, write RURAL and give neerest town) write RURAL and give nearest town? 46yrsllmos6dvs Sykesville Baltimore 24 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d STREET ADDRESS e. IS RESIDENCE ON A FARM? papers. Pag n 72, hours YES NO Springfield State Hospital Lombard Streat 3. NAME OF DATE Middle Day DECEASED OF (Type or print) DEATH 196] Marv Pol oha July 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. and last birthdey) Months White WIDOWED ! DIVORCED Female 1894 10a. USJAL OCCUPATION (G ve kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (County & State, or foraign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) Unknown Austria Austria 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME ding please Unknown Unknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) | (Ifyesgive war or detes of service) Νó Springfield Hospital Records 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Coronary Occlusion Minutes IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause **DUE TO** (a), sleting the underlying couse last. PART I. OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)) 19. WAS AUTOPSY IPERFORMED? Schizophrenic reaction, hebephrenic type, Bronchiectasis, NO 156 2De ACCIDENT WAS UNDERLYING | | 20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part | or Part | of item 18.) OR CONTRIBUTING CAUSE OF DEATH 20c. TIME OF INJRY Month, Day, Yeer 2Dd. INJURY OCCURRED! 2De. PLACE OF INJURY (Home, form. 20f. (City or town) (County) (Stete) factory, street, office bldg., etc.) Hour a.m. While Not While et work [at work 21. | certify that (I) (this hospital) attended the deceased from 8-19-..., 19.14 to 7-25-..., 1961, that (I) (we) last1961..., and that death occurred at. 7:00, from the causes and on the date stated above. saw the deceased alive on... 22a ZSIGNATURE ATTENDING SIGNED DIRECTOR 30 PHYS. PHYS. FUNERAL page 22d, ADDRESS PHYSICIAN'S NAME (Type) Julian Radzykewycz, M.D. Springfield Hospital, Sykesville, Md. filed v DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) 23a. BURIAL, CREMATION, 23b. (Slafa) REMOVAL (Specify) 0 256. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) arthur S. Thank 15M 9/60

RYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 07816 director, filed with ofter death. Page PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived of institutions Residence before admission) a. COUNTY **b.** COUNTY MARYLAND Maryland Carroll re funeral b. CITY OR TOWN (flouts de corporate limits, write c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lown) RURAL and give negrest town? (2) Baltimore Rural - Sykesville li vears li days d NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RES DENC OR INSTITUTION ON A FARM? 306 E. North Avenue YES NO TO Springfield State Hospital NAME OF Middle 4. DATE Month Day Year DECEASED OF. PURNELL (Type or print) Marv Florence DEATH S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8. DATE OF BIRTH AGE In years F UNDER 1 YEAR IF JNDER 24 HRS lost bighday) Months Doys Haves DIVORCED [10-26-72 WIDOWED 1 White Female 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 11. 8IRTHPLACE (State or foreign country) during most of working life, even if retired) 12 CIT ZEN OF WHAT COUNTRY? U.S.A. Maryland Teacher - Retired 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME Georgia Hall Edward D. Halbert 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT Address Hospital Records No 18 CAUSE OF DEATH | Enter only one couse per line for (o), (b), and (c) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE to DUE TO Conditions, if ony, which gave rise to immediate per **DUE TO** cause (a), stating the undering physician. He has been sig burial-transit i lying cause lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY emotion, PERFORMED? YES NO R 20a ACCIDENT WAS UNDERLYING A
OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II of rem 18) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY 20e. PLACE OF INJURY (Home, form, 20f (City or town) Doy, Year 20d. INJURY OCCURRED (County) (State) factory, street, office bldg., etc.) Hour o. m. While Not while at work p. m. at work 7-23 1961, that (We) last 21 I certify that (\$\mathbb{F}\$ (this haspital) attended the deceased fram. 7-19 saw the deceased alive an 7-23 19.61, and that death accurred at 3P.M. from the causes and an the date stated above DIRECTOR 220 SIGNATURE 22b DATE SIGNED ATTENDING MED DIRECTOR STAFF PHYS M.D. PHYS 22c PHYSIC AN'S 22d. ADDRESS NAME (Type) \ Gertrude M. Gross, M. D. Sykesville, Maryland 23d. BURIAL CREMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d EOCATION (City, fown, or county) (Stote) 2 7-28-61 Green Mount Baltimore 24 FUNERAL DIRECTOR'S SIGNATHER / DDRESS 25a REC'D BY REGISTRAR 25b REG STRAR'S SIGNATURE JUL 2 8 '61 WWILLIAM COOK, Inc. 1217 St. Paul St. BALTIMORE arthur & House 15M 9759



1		MANY LAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTI	MODE 1 MARYLAND	
FOR STATE		MEDICAL EXAMINER'S CERTIFICATE OF DEAT		
HEALTH DEPT.		PLACE OF DEATH 223	d. If Institutions Residence before admiss	Ωħ
\$ 8 . £		a. COUNTY 6. STATE 6. CO	OUNTY	/
Health Health	-	b. CITY OR TOWN (I outside corporate I mils, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate I mils,	Balto, City write RURAD and give neerest town!	-
ž Š Š Š		write RURAL and give nearest town)	3101	
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dela ed f		Springfield State Hospital 1818 E. Baltimore S	Street YES NO	M?
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er the		(Type or print) Elsie Rawlins DEATH Jr	uly 31 19 61	
eath 13+ 13+ Nith vith s aft	5.	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (in ya last birthder)	ay) Months Days Hours Min	rum rum
er d and 2 mg		Female White Widowed DIVORCED 12 yr	78.	"
1, 2, 1, 2, 99 5 and and 72 h	10a do	a. USUAL OCCUPATION (Give kind of work one during most of works) life, even if religied)	12. CITIZEN OF WHAT COUNT	(RY
ges Pas in I	475	FATHERS NAME Unknown	U.S.A.	
With	13.			
是是是	15.	Unknown WAS DECEASED EYER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Add	dress	
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Xect Lin I Day Lin I Lin I I I I I I I I I I I I I I I I I I I		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Softening of the brain	ONSET AND DEATH	
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of S. D. S.		gevertise to Immediata causa	Hours	
cate iner dass		(c) Myocardial failure	Days	
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is condition of the second of	3		YES NO	-
A sedio	CERTIFICA	206 EXTERNAL CAUSE WAS PRIMARY OR OF ONTRIBUTING CAUSE OF DEATH. CAUSE OF DEATH.		
September 19 19 19 19 19 19 19 19 19 19 19 19 19	14 -			
Military Boo	MEDICAL	20c. TIME OF INJURY Month, Day, Yeer 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or lown) factory, street, office bldg., atc.)	(County) (State)	
X P H N O	W.	p.m. 19 at work - at work -		
Figure 1	H	21. I certify that I took charge of the remains described above, held an Autopsy X, Inspection X, Inc	(40)	n
Sept de la		death resulted from: Natural causes X Accident . Suicide . Homicide . Undetermined	d manner	
the certwards DIRE	\vdash	ACTUAL CHIEF MEDICAL EXAMINER C	DATE SIGNED	
200.2		SIGNATURE ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER	7-31-61	
Sign Page		NAME (Typh) James T. Marsh, M.D. Address (Street, city, town, or county) We	, , , , ,	
DECUTA 1 ease execute should be it FUNERAL its designal	228	BURIAL, CREMATION, 226. DATE THEREOF 220. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, to		=
0 0 4 0 p		Bureal 8-3-61 Alag Ford Julia to	oxy Venn.	
VS. A15ME	23,	FUNCTAL PRECTOR ADDRESS - 1 240. REC'D BY REGISTIAR 246.	REGISTRAR'S SIGNATURE	
5M 7/59	1	Cuthe Fr. Halght (Typisoell; The DATE AUG 3 "61	arthur & Krous	
	7			



	MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
	CERTIFICATE OF DEATH Reg. Dist. No. 97818
1)	1. PLACE OF DEATH COUNTY Carroll MARYLAND 2. USUAL RESIDENCE (Where deceosed lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll
	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Westminister C. LENGTH OF STAY IN 1b C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frizzelburg
	d NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Carroll Co. Home for Aged 6. IS RESIDENCE ON A FARM? YES \(\sum \) NOTE
	3. NAME OF DECEASED (Type or print) James Roy Sherfey DEATH July 23 19 61
	5 SEX male 6 COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH Sept. 12, 1890 9. AGE (In yeors IF UNDER 1 YEAR IF UNDER 24 HRS Northdoy) Months Doys Hours Min.
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.
1	Samuel D. Sherfey Amanda Kump
<i></i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT Paul Sherfey Rocky Ridge, Md.
	18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and de/]
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) US HITING
	Conditions, if day, which the Hel Kirstensson - The out
	gove rise to immediate couse (o), stoling the under- lying couse lost. DUE TO Cardio Das Cultar Descare Characio
	PART II. OTHER SIGNIFICANT CONDIT ONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO 1
1	200 ACCIDENT WAS UNDERLYING 206 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
	20c. TIME OF INJURY Month, Doy, Yeor 20d INJURY OCCURRED While Not with of work of wor
	21. I certify that I attended the deceased from 1955, 19, to 7-22 196, that I last saw the deceased
	alive an
z	SIGNATURE W. C. S. LOZIO M.D. TYZA THENESE 25 7-25-
S.	PHYSICIAN'S 72. C. STG2181
	220. BJRIAL, CREMAT ON. 22b DATE THEREOF T-25-61 Creagers town Cemetery Creagers town, Md. (Stote)
	23 DINERAL DIRECTOR'S AGNATURE ADDRESS ADDRESS
	pare 11 20 61



DIVISION OF STATISTICAL RESEARCH AND RECORDS - BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH il director, filed with PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE o. COUNTY b. COUNTY MARYLAND funeral aid be fi b. CITY OR TOWN (If outs de corporale limits write CITY OR TOWN of outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 RURAL and give nearest towal the functional d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? in by and 2 YES NO Z NAME OF 4. DATE First Middle Month Last Day Year DECEASED death. DEATH (Type or print) 19 SGE (in years IF UNDER I YEAR IF UNDER 24 HRS SEX/ 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 19-8. DATE OF BIRTH completely lost birthdoy! after Months Doys Hours DIVORCED [7] papers. WIDOWED / 100 USLA OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR INDUSTRY defing most of working life, even if retired) hours 12 CITIZEN OF WHAT COUNTRY? pup 14. MOTHER'S MAIDEN NAME physician S. ARMED FORCES 16. SOCIAL SECURITY NO 17 INFORMAN attending CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c)] INTERVAL BETWEEN ONSET AND D ă PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO permit. Conditions, if only, which After this certificate has been signed gove rise to immediate **DUE TO** couse (a), sloting the underlying couse lost. **burial-transit** ar attending physician PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES 🗍 NO 🕻 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. Inter noture of injury in Port I of Port II of Item 18 (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, farm, | 20f (City or town) (County) (Stote) foctory, street, office bldg., etc.) Hour o.m Not while While at work of work p, m Far prior 21 | certify that (1) (this haspital) attended the deceased from the control of the control of the certify that (1) (this haspital) attended the deceased from the certify that (1) (this haspital) attended the deceased from the certify that (1) (this haspital) attended the deceased from the certification of the certificatio . thot (I) (we) last detached sow the deceased alive on ~ 19 and that dooth occurred a M, from the cooles and an the date stated obave DIRECTOR: 220 SIGNATURE M D PHYS STAFF DIRECTOR [22c PHYSICIAN 22d ADDRESS 3 should NAME (Type O FUNERAL 230 BURIAL CRIMATION, 236 DATE THEREOF 23d LOCATION (City town, or county, 23c NAME OF CEMETERY OR CREMATORY page MOVAL (Specif UNERAL DIRECTOR'S SIGNATURE 256 REGISTRAR'S SIGNATURE **ADDRESS** D BY REGISTRAR arthur S. Kraus 15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

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1. PLACE OF DE	ATH			2, USUAL RESIDENCE	CE (Where decease	ed lived. If instituti	on-Residence be	efore admission)
o. COUNTY	Carroll		MARYLAND	a. STATE		b. COUNTY		
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	give neorest town	orporote limits, write)	c LENGTH OF STAY IN 16	CITY OR IOW	N (If outside corpo	orote limits, write R	UKAL and give i	nearest tawn)
Rura	1 Keyma:	r		X Rura	al Keyman	r°		
d. NAME OF OR INSTIT	HOSPITAL (If not i	n hospital, give stre	et address}	d. STREET ADDR	ESS			e. IS RESIDENCE ON A FARM? YES NO T
			-,-	11				
3. NAME OF DECEASED		First	Middle	Last	4. DATE	Mon	eth	Day Year
(Type or print	t)	John	Norris	Starr	DEATH	July_		4 1961
5. SEX	6. COLO	R OR RACE 7. MA	ARRIED NEVER MARRIED	B DATE OF BIRTH		9. AGE (in years		AR IF UNDER 24 HI
1/07-	7377- 4	- Wino	WED TO DIVORCED	T 2 70	one	last birthday)	Months Day	rs Hours Min
Male	Whi:	40	% KIND OF BUSINESS OR INDU	June 2, 18	5/7 #### []	0.0	12 CITIZENI	OF WHAT COUNTR
during most	of working life, ev	ren if retired)	E KIND OF BUSINESS OK INDI	DELKT II BIKIMPLACE	(atore or roreign	country;	12 CHIZEN	OF WHAT COUNTR
Contr	actor		Building	Carrol	1. Co., Ma	arvland	U.S.	.A.
3. FATHER'S NA	AME			14. MOTHER'S MAI	IDEN NAMÉ	0		
* -	m (1).			W. D	0 -			
	T. Star		Table 1	Mary R.	. Crouse	4.1.4		
(Yes, no, or unknown	SED EVER IN U. S. (If yes, give w	ARMED FORCES?	6. SOCIAL SECURITY NO. 17	INFORMANT		Add	lress	
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	OF DEATH Enter		line for (o), (b), and (c).]	A	7_			NTERVAL BETWEEN
	T I DEATH WAS C			0 9.	Property			NSET AND DEATH
1718	IMMEDIA	TE CAUSE (a)	Jew	un.)			
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	ns, if ony, which	160						
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	stating the <u>under-</u>							
lying cous) (c)						1
PART	I OTHER SIGNIF	ICANT CONDITION	S CONTRIBUTING TO DEATH BU	T NOT RELATED TO THE	ETERMINAL DISEA	SE CONDITION GIV	VEN IN PART 1(o	PERFORMED?
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- 20m ACCID	ENT WAS UNDERL	YING D 206 D	ESCRIBE HOW INJURY OCCURR	ED. (Enter noture of inju	ury in Port I or Po	rt II af item 18.)		
OR CONTRI	ENT WAS UNDERLIBUTING CAUSE NOTIFY MEDICAL I	OF DEATH						
	FINJURY Month, a.m.		I.	LACE OF INJURY (Homo octory, street, office bld	e, form, 120f (Cit	ly or town)	(Caun	aty) (Sto
Hour	p. m.	19 Wh	ile Not while "	-	1			
				0011	11.1.1	0.0.	16.11	
21 1 certi	ify that (I) (thi	s haspitally afte	aded the deceased from	Jackson !	8, 19 6.L., ta	yung	Z. 1961.	that (I) (we) lo
saw the	deceased alive	an	4.3 196 and that	death accurred at	M, fran	The causes ar	nd an the do	ate stated abov
220 SIGNA	TURE	1/1/ -1	U		7-1-1			22b DATE
	- /	MY Z	ena	M D PHYS	MED DIRECTOR	STAFF PHYS		SIGN
22c PHYSIC	TAN'S	1-1-1	A	22d, ADDRESS	J DIRECTOR E	, 11113 []		- 1
NAME		HI	ENGINE	7 /	1	2	1	mil
		1/1	- 07 01 /1 12	- U	non	Iw	ogh	IRCK
23a BURIAL, CR	REMATION, 236.	ATE THEREOF	23c NAME OF CEMETERY	OR CREMATORY	23d. LOC/	ATION (City, town,	ar county)	(Stote)
REMOVAL		lv 6. 196	1 Pippe Creek C	emeterw	Rura	l New Win	dsor M	arvland
	about and in the	mr/ / 2 /	ADDRESS		REC'D BY REGIS		ISTRAR'S SIGNA	
15-61	USS / Jyes	CINCICE					water S. A.	
C.O.I	Tuss & So	n I	laneytown, Mary	land DA	ATE JUL 7	'61	waterway as 14	Vana

may by Tevained by the hospital or attending physician.

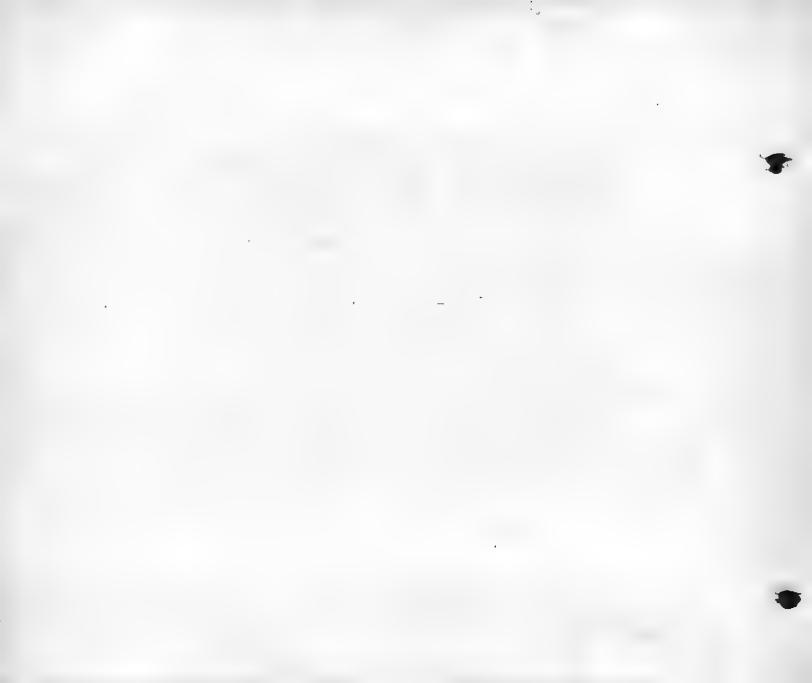
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physic page 3 shauld be detached far use as the burial-transit permit. Then please remave the State Board of Health priar to burial, cremation, or removal, and in any event, with VR A15 (4) 15M 9/59

ours after death. Page 4

ALOR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24.

n by the funeral director, and 2 shauld be filed with

event within 72 hours after



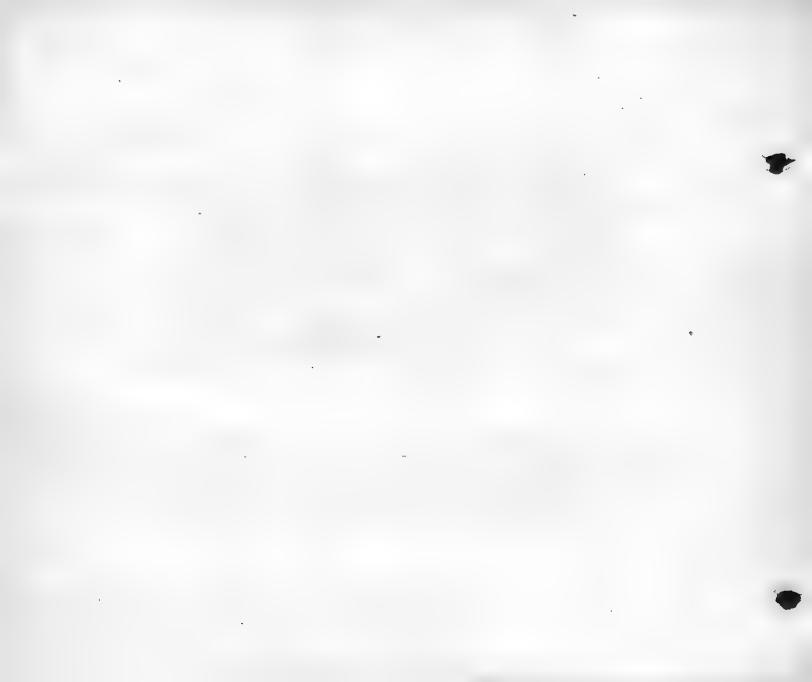
DIVISION OF STATISTICAL RESEARCH AND RECORDS --- BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH I director, filed with PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. COUNTY MARYLAND -arroli c. LENGTH OF STAY IN 16 CITY OR TOWN (If outside corporate limits, write c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL grad give negliest lowel the fund mchester d NAME OF HOSPITAL (If not in hospital, give street address) on A FARM? OR THIS TUTION 5 07/5 YES NO pup ç NAME OF 4. DATE OF First Middle Last Day DECEASED death. DEATH Pages (Type or print) 8. DATÉ OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS SEX 7 MARRIED NEVER MARRIED last birthday) Months Hours WIDOWED DIVORCED T off USUAL OCCUPATION (Give kind of work done during must of working life, eyen if retired) 10a USUAI 12. CITIZEN OF WHAT COUNTRY? buo 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15 WAS DECEASEDEVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no. or unknown) (If yes, give wer or date of service) 17 INFORMANT attendi 18. CAUSE OF DEATH | Enter only one couse per line factor INTERVAL BETWEEN ONSET AND DEATH I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (c) **DUE TO** ģ Conditions, if ony, which gned gove rise to immediate DUE TO couse (b), stoting the underlying cause lost burial-transit ä PAINT 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS ALTOPSY PERFORMED? 200 ACCIDENT WAS UNDERLYING TO OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18) <u>e</u> 20c. TIME OF INJURY 20e. PLACE OF INJURY (Home, form, Day, Year 20d INJURY OCCURRED 20f. (City or town) (County) factory, street, office bldg , etc.) a. m While Not while at wark at work p. m. 19 📲 21 I certify that (I) (this hosp[tal) attended the deceased from LY 1961, that (1) (we) lost and that death accurred at 233M. From the Guses and on the date stated above. sow the deceased ofive on MIRECTOR: 220 SIGNATURE ATTENDING MED. STAFF Ŷ. ê. MD PHYS. Board 22c PHYS CIAN'S NAME (Type) 22d. ADDRESS HUMBERAL page 3 the Stat DATE THEREOF METERY OR CHEMATORY LOCATION (Chr. town, (0 0 25b REGISTRAR'S SIGNATURI VR A15 (4 Chilling S. Thomas 31 '61 DATE 15M 9/59

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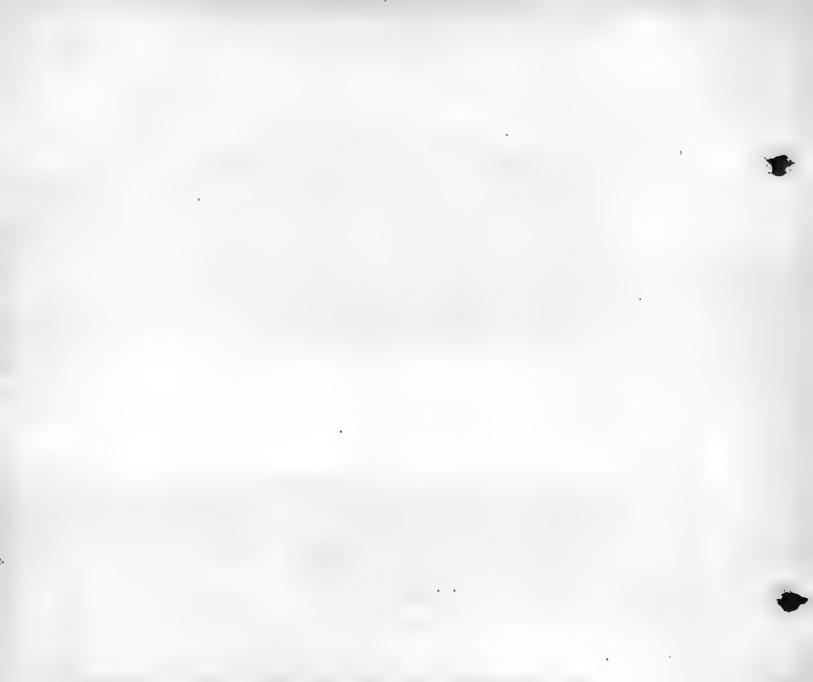
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(Stote)

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CERTIFICATE OF DEATH I. PLACE OF DEATH d. COUNTY CATTOIL b CTY OR TOWN (If outside corporate limits, write county) RURAL and give necrest fown) Sykesville d NAME OF hospital. (If not in hospital, give street address) OR INSTIBUTION SPITINGFIELD State Hospital John Thomas Swan 4. DATE OF DECEASED (Type or print) S SEX 6. COLOR OR RACE White Wildows Maryland 100. USUAL OCCUPATION (Give kind of work done during most of working life, even if refired) NOR OF HOSPITAL (If not in hospital). Give kind of work done during most of working life, even if refired) DIVORCED 100. USUAL OCCUPATION (Give kind of work done during most of working life, even if refired) NAME OF DECEASED EVER IN U. S. ARMED FORCES? 101. WAS DECEASED EVER IN U. S. ARMED FORCES? 102. WILLIAM D. SWAN 115. WAS DECEASED EVER IN U. S. ARMED FORCES? 116. SOCIAL SECURITY NO 117. INFORMANT Add 118. CAUSE OF DEATH [Enter only one cause per time for (p), (b), and (c).]								
ACCOUNTY Carroll b CTY OR TOWN (If autiside corporate limits, write related to the corporate limits, write related to the rel	07822							
Carroll b CTY OR TOWN (if outside corporate bmits, write RURAL and give nearest town) A NAME OF HOSPITA. (if not in hospital, give street address) OR INSTITUTION SPTINGFIELD State Hospital 3. NAME OF DECEASED (Type or print) SEX 6. COLOR OR RACE White Widow Thomas SWAN A DATE OF ANT OF A	Residence before odmission)							
RURAL and give nearest town) Rural) Sykesville d NAME OF MOSPITA. (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital 3. NAME OF DECEASED (Type or print) S SEX 6. COLOR OR RACE White Widdle Thomas Swan 4. DATE OF DEATH 7 Mandle Swan 5. SEX 6. COLOR OR RACE White Widdle DIYORCED DIYORCED 11-9-1885 9. AGE (In years lost birthdoy) Off by rs 100. USUAL OCCUPATION (Give kind of work done lob kind of Business OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) 100. USUAL OCCUPATION (Give kind of work done lob kind of Business OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) 100. USUAL OCCUPATION (Give kind of work done lob kind of Business OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) 100. USUAL OCCUPATION (Give kind of work done lob kind of Business OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) 100. USUAL OCCUPATION (Give kind of work done lob kind of Business OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) 101. MOTHER'S MAIDEN NAME William D. Swan 102. WAS DECEASED EYER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Add	HAL Carroll							
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OR INSTITUTION SPINING FIRST 3. NAME OF DECEASED (Type or print) 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years lost birthdoy) 75 yrs 10c. USUAL OCCUPATION (Give kind of work done of the fredired) 11-9-1885 75 yrs 10c. USUAL OCCUPATION (Give kind of work done of the fredired) 10b KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME 14. MOTHER'S MAIDEN NAME William D. Swan 15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Add 15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Add	e IS RESIDENCE							
S SEX	ON A FARM? YES NO							
male white widowed Divorced 11-9-1885 1031 5 75 yrs 100. USUAL OCCUPATION (Give kind of work done during most of working life, even if refired) none Maryland 13 FATHER'S NAME William D. Swan 15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Add Add Add Add	boy Yeor 61							
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(Yas, no, or unknown) . (If we nive was or distent of service)								
unknown Hospital Records	BSS .							
CHIMITAL I MODEL OF THE COLUMN								
1B. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).]	ONSET AND DEATH							
PART I DEATH WAS CAUSED BY Bi-lateral Pneumonia	days							
THE DUE TO								
Conditions, if any, which (b)								
cause (o), stating the <u>under</u> .								
lying cause last.) (c) (c) Print of the Control of	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDIT ON GIVEN IN PART I(0) 19 WAS AUTOPSY							
Schizophrenic reaction, hebephrenic type.								
200 ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	127 10							
20a ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								
	(County) (Stote)							
20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED While Nat while at work at work at work at work								
	, 1%1, that (i) (we) last							
sow the deceased alive on 7/9 1961, and that death occurred at 8:30, from the causes or								
22g. SIGNATURE	22b, DATE							
Jarva Johanna M D ATTENDING DIRECTOR STAFF PHYS &	7-9-61. SIGNED							
22c PHYSICIAN'S NAME (Type)								
Yasuo Takahashi M.D. Springfield State Hos	pital							
23a BLR AL, CREMATION, 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City Jown,	county) (State) /							
Busing 7-14-61 Freedom Ofishinde 19								
	enollo, med,							
Quitate A. Aught Systemalle, Mid DATELUE 17'61 Con	STRAR S SIGNATURE							



W. PRESTON STREET, BALTIMORE 1, MARYLAND DIVISION OF STATISTICAL RESEARCH A 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) 1. PLACE OF DEATH b. COUNTY Carroll e. COUNTY Maryland Carroll MARYLAND b. CITY OR TOWN (if outside corporate limits, C. LENGTH OF STAY IN 15 c. CITY OR TOWN (If outside corporate I mils, write RURAL and give nearest town) write RURAL and give neerest town? Finkaburg, Finksburg Vrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospite., give street address) a. IS RESIDENCE ON A FARM? Old Westminster Road Old Westminster Road KI ON I SAY 3. NAME OF 4. DATE Middle Month DECEASED DEATH (Type or print) John Martin Taylor July 19 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B DATE OF BIRTH IF UNDER 1 YEAR 5. SEX 9. AGE (In years) last birthdey) Months | Days Male WIDOWED X DIVORCED [12. CITIZEN . WHAT COUNTRY 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY, 11, BIRTHPLACE (County & State, or foreign country) done during most of working life, even if refired) England England Turnkev at Jail iding ph please r 13. FATHER'S NAME 1.14. MOTHER'S MAIDEN NAME Orpah Martin Frederick Tavlor S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) (Hyesgivewerordelesofservice) rs.Mildred DeMoss, Finksburg, Md. 18. CAUSE OF DEATH [Enter only one cause per my for (e), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) DUE TO Conditions, if eny, which gave rise to immediate cause DUE TO (a), stelling the underlying PART I., OTHER SECNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT SELATED TO THE TERMINA, DISEASE CONDITION GIVEN IN PART I(6) 19. WAS AUTOPS 206 DESCRIBE HOW NJURY OCCUPED, (Enter nature of musy in Port I or Part I of Item 18.) 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING [] CAUSE OF DEATH 20c. TIME OF INJURY 20d. NJURY OCCURRED OG. PLACE OF INJURY (Home, farm, (County) 201. (City or town) Month, Dey, Yeer Not While factory, street, office bldg . etc. Hour a.m. al work at work 21. I certify that (I) (this hospital) attended the deceased from., and that death occured at AM, from the causes and on the date stated above saw the degeased alive on... 22a. S.GNATNRE STAFF ATTENDING PHYS. DIRECTOR PHYS. FUNERAL 22d. ADDRESS 22c. PHYS/CIAN ector, 23d. LOCATION (City, town or edunty) AME OF CEMETERY OR CREMATORY 238. BURIAL, PREMATION, | 236 DATE THEREOF REMOVAL/(Specify) O 를 및 St.Thomas Cemetery Owings Mills. Md 24 FUNERAL DIRECTOR'S SIGNATURE 25e. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) DATEUL 1 8 '61 J.F. Eline & Sons, Reisterstown, Md. arthur L. Frank 15M 9/60



DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH director PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived If institution Residence be filed o. COUNTY b. COUNTY MARYLAND funeral ald be fi b. CITY OP TOWN (If outside corporate limits, write RURA) and give nearest town. c. LENGTHTOF STAY IN 16 c. CITY OR TOWN (Il/Burside perparate limits, write RURAL and give nearest town) MAME OF HOSPITAL (If not in hospital, give street address) STREET ADDRESS e. IS RESIDENCE ON A FARM YES NO NAME OF Middle Last 4. DATE Month Year DECEASED DEATH (Type or print) AGE (In years lost birthdoy) S SEX 6 COLOR OR RACE IF UNDER 1 YEAR IF UNDER 24 H MARRIED NEVER MARRIED | Manths Doys Hours DIVORCED | WIDOWED 1 10a USUAL OCCUPATION (Give kind of work done 10b/KIND OF BUSINESS OR INDUSTRY 1.1, BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY? 3. FATHER'S NAME 14. MOTHER'S MAIDEN NAM .⊆ mave IS WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT Addtess пg 18. CAUSE OF DEATH [Enter only one cause per type for (o), (b), and (c). INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (6) DUE TO ģ Conditions if any, which gave rise to immediate **DUE TO** couse (a), stating the undertying couse last PART II. OTHER SIGNIFICANT CONDITION S CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES I NO I 200 ACCIDENT WAS UNDERLYING A
OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, 20e PLACE OF INJURY (Home, form, 20f. (City or town) Day, Year 20d. INJURY OCCURRED (County) (Stote) foctory street, office bldg., etc.) Hour a.m. While Nat white at work ot wark p m. 21 I certify that (1) (this hospital attended the deceased from . 19 . . that (1) (we) last and that death accurred and PM, from the causes and an the date stated above saw the deceased alive an 20 DIRECTOR 22a S GNATJR ATTENDING PHYS MO DIRECTOR 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type 23g BURIAL CREMATION. OF CEMETERY OR GREMATORY 23d LOCATION (City, town, occounty) AState) EMOVAL (Specify 0 24 FUNERAL DIRECTOR'S SIGNATU 25b. REGISTRAR'S SIGNATURE withing & Kroud DATE 1SM 9/59



RYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 78MIDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution, Rasidance before admission, a. COUNTY Chevy Chase, Montgomery director. Page Maryland Carroll MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outs'de corporate limits, write RURAL and give nearest town) for your write RURAL end give neerest town) 14yrs.7mos.12dys Chevy Chase Sykesville
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street eddress) d STREET ADDRESS YES NO X Springfield State Hospital 4504 Ridge Street 3. NAME OF 4. DATE Middle DECEASED OF (Type or print) DEATH Wolford Hollingsworth 70 19 61 July George 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months WIDOWED [DIVORCED -April 3, 1899 62 yrs. Male White 10a. USJAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11. B.RTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? dona during most of working life, even if retired) U.S.A. Maryland Bicycle repairman 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Elizabeth M. Allison Harry C. Wolford 15. WAS DECEASED EVER IN J.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT (Yes, no, or unkown) | (Ifyes give weror detas of service) Fouls be executed with the second of the sec Springfield Hospital Records No 18. CRUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSEJ AND DEATH PART I. DEATH WAS CAUSED BY: Acute myocardial infarction IMMEDIATE CAUSE (a) DUE TO Coronary arteriosclerosis Years Conditions, if any, which (b) gava rise to immediate cause **DUE TO** (a), steting the underlying cause last. PART II. OTHER SIGNIF, CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTOPSY PERFORMED? Paranoid condition. plus Friedreich's ataxia. plnous 200. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of Item 18.) PRIMARY | or CONTRIBUTING | /age 3 should be forwarded to the Chief Front RAL DIRECTOR: Page 3 s 20c. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, ferm, 1 20f. (City or town) (County) (Stata) factory, street, office bldg., etc.) While Not While Hour a.m. at work . at work . prior 21. I certify that I took charge of the remains described above, held an Autopsy X. Inspection X Inquiry K and in my opinion Natural causes X Accident Suicide Homicide Undetermined manner death resulted from. CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER DATE SIGNED SIGNATURE DEPUTY MEDICAL EXAMINER TH 7-10-6] James T. Marsh, M.D. NAME (Type) Address (Street, city, town, or county) 22c. NAME OF CEMETERY OR CREMATORY 22d, LOCATION (City, lown, or country) (State) 22a. BURIAL, CREMATION, 22b. DATE THEREOF REMOVAL (Spacify) Rockville, Maryland Rockville Cemetery E40 9 Burial 24a. REC'D 8Y REGISTRAR | 24b. REGISTRAR'S SIGNATURE ADDRESS 23. FUNERAL DIRECTOR VS. A15ME Cirching S. France Pumphrev Bethesda, Maryland DATEJUL 13'61 Robert A. 5M 7/59



DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH director | PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a COUNTY 8 b. COUNTY MARYLAND Carroll Marvland Balto. eral b. CITY OR TOWN (If outside carporate limits, write. c LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) D 3 mos.16dvs. Sykesville Baltimore 7 d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE YES NO 3512 Hillsmere Road Springfield State Hospital 4. DATE Middle Month Year DECEASED (Type or print) Abbiegale DEATH Yealdhall July 10 1961 6. COLOR OR RACE B DATE OF BIRTH 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED T NEVER MARRIED last birthday) Months WIDOWED | DIVORCED | November 18, 1883 Female 10a USLAL OCCLPATION (Give kind of work dane 10b KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State ar fareign country) during most af working life, even if retired) 12 CITIZEN OF WHAT COUNTRY? U.S.A. Bookkeeper/Housewife Maryland 3. FATHER'S NAME 14 MOTHER'S MAIDEN NAME George Nichols Susan Green WAS DECEASED EVER JIN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT Address Springfield Hospital Records No 1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (g) Heart failure days DUE TO Arteriosclerotic heart disease vears Canditions, if any, which gave rise to immediate **DUE TO** cause (a), stating the underlying cause last. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? cerebral arteriosclerosis with psychotic reaction. litus. Bronchopneumonia. YES 📆 NO 🗍 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) CERT OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, ; 20f. (City or town) (County) (State) factory, street, affice bldg., etc.) Haur a.m. Not while at work at work p. m. 21 1 certify that (1) (this haspital) attended the deceased from. 3-24-, 19.61, to 7-10-, 19.61, that (1) (we) last 7-10- 1961, and that death accurred as: 58MP fills the causes and an the date stated above. saw the deceased alive an 22a SIGNATURE SIGNED MED DIRECTOR PHYS 7-10-61 22d ADDRESS Springfield State Hospital gustin del Campo. M.D. 23c NAME OF COMETERY OR CREMATORY 23d. LOCATION (City/town, or county) 0 250. REC'D BY REGISTRAR 256 REGISTRAR'S SIGNATURE Cirthun S. Kroue 15M 9/59

iurs after death.



CERTIFICATE OF DEATH 7835 Reg. Dist. No. director PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) Filed a. COUNTY b. COUNTY MARYLAND uneral b. CITY OR TOWN (If outside carporote limits, write C. LENGTH OF STAY IN 16 c. CITY, OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL and give negrest town) Po d. NAME OF FIOSPIYAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION YES TO-NO NAME OF Middle 4. DATE Last Month Day Year DECEASED OF (Type ar print) DEATH 196 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 9. AGE (In years last birthday) Months Days Haurs WIDOWED | DIVORCED | 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY during most of working life, even if retired) 11. BIRTHPLACE (State or fareign country) 12. CITIZEN OF WHAT COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME гетауе AVAS DECEASED EVER IN U. S. ARMED FORCES? 17. INFORMANT 16/SOCIAL SECURITY NO Address othending 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate **DUE TO** cattse (a), stoting the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO E 20°. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, 20f. (City ar town) (County) (State) Ноег factory, street, office bldg., etc.) a. m. While Nat while of work of work p. m. UVLT 14 1961, that I lost sow the deceased 21. I certify that I ottended the deceased from and that death occurred at 1/000 M, from the causes and on the date stated above. alive on ADDRESS (Street, city or town, state) ACTUAL DIREC SIGNATURE PHYSICIAN'S NAME (Type) -------22g. BURIAL, CREMATION. 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county)poge (State) REMOVAL (Specify) 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 240. PEC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Orthur S. Kraus 8 6 DATE 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Management of the second of th But led to 24 A feath and in the Burner of the

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 7835 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If Institution, Residence before edmission, a. COUNTY b. COUNTY Carroll Maryland MARYLAND Balto, City b. CITY OR TOWN (if outside corporete limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporete limits, write RURAL and give neerest town) write RURAL and give nearest town) Sykesville 5mos.13days Baltimore 6 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d STREET ADDRESS IS RESIDENCE ON A FARM? Springfield State Hospital 3621 White YES NO TO 3. NAME OF Middle 4. DATE Month Day Yeer DECEASED (Type or print) Alvin Zschunke DEATH 14. 1961 July 5. SEX 6. COLOR OR RACE 7. MARRIED TO NEVER MARRIED B. DATE OF BIRTH 9. AGE (In yeers | IF UNDER I YEAR IF UNDER 24 HRS. last Ainhdey) Male July 6, 1879 WIDOWED I DIVORCED 10e. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) U.S.A. Accountant Maryland ding ph 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Gothold Zschunke Ernestine Theme 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) (If yes give we ror detesol service) Springfield Hospital Records 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Septicemia IMMEDIATE CAUSE (e) Days DUE TO Infected bed sores Conditions, if eny which Weeks gave rise to immediate ceuse DUE TO (a), steting the underlying cause lest. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) 19. WAS AUTOPSY CERTIFICATION assoc. with senile brain disease with psychotic reaction. PERFORMED? NO X 20e. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert I or Pert II of item 18. OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20c. TIME OF INJURY Month, Dev. Yeer 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or lown) (County) (Stete) factory, street, office bldg., etc.) Not While Hour a.m. While et work at work 21. I certify that (I) (this hospital) attended the deceased from February 1, 19.61 to July 14, ..., 19.61that (I) (we) last JULY 14, 19 61, and that death occured 8:45AM from the causes and on the date stated above 22b. DATE 22a. SIGNATURE 7/14/61 SIGNED ATTENDING PHYS. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Julian Radcykowycz / M. D Springfield Hospital. Sykesville. Md. 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) 23e. BURIAL, CREMATION, | 23b. DATE THEREOF (State) MOVAL (Specify) 24 FUNERAL DIRECTOR'S SIGNATI 25a, REC'D BY REGISTRAR 25b, REGISTRAR'S SIGNATURE **VR A15 (4)** 15M 9/60 DATE JUL

RYLAND STATE DEPARTMENT OF HEALTH

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